

## Surgery

### Acute Peptic Perforation

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In the field of abdominal emergencies there is nothing more urgent than the prompt recognition of free gastric or duodenal perforations. There is nothing more tragic than death as a result of failure to diagnose an acute perforation; tragic, not only because of its suddenness, but because the patient is more often in the prime of life and organically sound except for this one lesion. A catastrophe has occurred so serious as to set a time limit in hours on the very life of the victim. No other curable disease except perhaps concealed haemorrhage occurs with less warning and demands so accurate a diagnosis and so prompt treatment.

It is, therefore, necessary that we as medical men be entirely familiar with the clinical manifestations so that no valuable time be lost.

The proven success associated with early operation and the proven disaster without it has placed free acute perforations high up, if not at the very top of the list of surgical triumphs. There is nothing in the field of surgery which gives to the patient and surgeon alike more prompt results and greater satisfaction than the early and efficient management of the patient suffering from acute perforation. Adequate treatment or surgical repair within six or eight hours is attended with few or no fatalities. After forty-eight hours it is attended with few or no recoveries.

Fortunately, the history, signs and symptoms are in the vast majority of cases sufficiently typical to make the diagnosis fairly easy. No time need be lost, nor is any indecision permissible once the diagnosis is made for there is only one generally accepted treatment; viz., immediate operation. Formerly one could make this statement without fear of contradiction. More recently, within the past three years, it must be made with justifiable reservation due to the results which have been obtained by continuous aspiration and decompression of the stomach. Large series of cases have been reported from various sections of the continent recording results which are comparable with those obtained by surgery. Reference will be made to this later on when we are discussing treatment.

The term "perforating" as applied to peptic ulcers implies a much slower process, characterized by a steady boring type of pain. This ulcer is usually posterior or occurring on some part of the stomach wall which anatomically is adjacent

to another organ, either the pancreas, liver or even the transverse colon. The inflammatory process creates adhesions so that when the ulcer finally eats through the wall the adjacent margins are sealed so firmly to another viscus that leakage is minimal or entirely prevented. This process occurs most typically on the posterior surface where dense adhesions to the pancreas completely confine the gastric or duodenal contents. If there is leakage it is slow and will be confined to the lesser sac. Accumulation of leakage will sooner or later find its way through the foramen of Winslow to the more sensitive general peritoneal cavity. Fortunately, however, most posterior ulcers are hermetically sealed before perforation occurs. For ulcers of the lesser curvature the protecting organ may be the liver.

Today we are interested in the acute anterior or so-called "free" perforation which means spilling into, and soiling of, the peritoneal cavity. Our remarks will be confined to this type. The term "peptic" is used because it includes both sites—gastric and duodenal.

The incidence of duodenal- is much greater than that of gastric-ulcers so naturally duodenal perforations are much more common. Peptic ulcers occur much more frequently in males than females. For the same numerical reason acute perforations are infinitely more common in the male population. The ratio varies in different countries. In this country the perforation ratio is about twenty to one.

The type of individual is more often the thin, nervous type who has suffered for years from dyspepsia and who has tried many remedies recommended from as many sources. He has probably learned that his gnawing or boring epigastric pain is relieved by soda, milk or food, and will tell you he has taken soda or somebody's powders for years. Often he will report seasonal or periodic relief attributed to the medication of the moment. An exacerbation of the pain may have been present for a few hours prior to perforation and in an attempt to get relief a large meal or an unusual quantity of milk or water may have been ingested, when suddenly the ulcer "blows out." It is said that acute ulcers perforate more commonly than chronic. This is not the rule in our experience. In the majority of our cases a long ulcer history precedes the catastrophe. Strictly speaking it is an acute perforation of a chronic ulcer. The ulcer-bearing patient must always carry the potential risk of perforation.

In my own series of cases the patient has as a rule been about his work with nothing more than his usual discomfort, when suddenly he is seized with a terrific abdominal pain, completely incapacitating him. He is helped to bed or arrives home with the greatest of difficulty. A typical example is that of one victim who was seized soon after a large mid-day meal. He was driving a binder when the perforation occurred and was rendered prostrate for a time. He finally was obliged to walk and crawl some distance to his home before help was summoned. His doctor promptly diagnosed the condition, gave morphia and brought him some eighty miles to hospital where operation was completed within six hours. Recovery was uneventful in spite of gross soiling of the peritoneal cavity. In this instance it was a gastric perforation and the hole large. Gastric perforations are usually larger than duodenal and I have found wider areas of scar tissue about the site of perforation. The greater area of stomach wall allows for wide excision and eversion of the ulcer bearing area and if necessary the adjacent scar tissue to facilitate closure. In the days before the establishment of the Levine tube and continuous suction, the closure of duodenal perforations often produced a stenosis. To overcome this hazard, the surgeon was obliged to add a posterior gastro-enterostomy to his emergency procedure. Today the effect of the temporary stenosis can be safely controlled by means of the continuous suction apparatus—and gastro-enterostomy is seldom required.

#### Early Signs and Symptoms

The patient suffering from an acute perforation is not at all likely to be consulting you at your office. You will be called to see him and the call will be urgent. It is not likely that he personally will be doing the telephoning, nor will the message describe the victim as walking the floor or rolling about in agony. He will be lying just about where he happened to be when the pain struck him. If he has been helped to bed his clothes will still be on.

When you arrive your patient will be lying on his back. At this stage his appearance will be that of one suffering from shock caused by pain. Actually it is not real shock as we define it, it is prostration. He is not talkative, but will answer questions clearly with short, grunting articulations. His only concern is for the prompt relief of this awful pain which has not let up for a second since its sudden onset.

At this early stage, if he is seen within the first four to six hours, neither the pulse nor the temperature will be significantly altered. The blood pressure may be reduced from normal. The respirations are short and distinctly thoracic in type. Vomiting may or may not have occurred. It is far from being a typical symptom. In my

experience, which has in the course of years become considerable, I have found the symptoms of vomiting and haemorrhage, or blood-stained vomitus to have been conspicuous only by their absence. Certainly vomiting is not a delay. There may be good reason for its absence. If vomiting has occurred into the peritoneal cavity

You will remember Osler's famous dictum: "The ulcer that bleeds does not perforate." It is still a pretty safe rule.

The severity of the symptoms are to a degree rendered more severe by the history of a recent meal and a full stomach. Do not be misled by the less typical findings for the case which has presumably perforated many hours after food intake; e.g., early in the morning or the patient who has gone to work without breakfast.

Again if the patient is not seen for several days to twenty-four hours after perforation occurs the clinical picture may be sufficiently altered to provide greater difficulty in making an accurate diagnosis. The typical rigidity may be less pronounced and the pain less severe. Distention is likely to be present and audible intestinal peristalsis absent.

The early typical diagnostic signs and symptoms are five in number:

1. The sudden onset of a severe, agonizing upper abdominal pain which remains constant in character and intensity. It is not colicky in character.
2. A generalized board-like rigidity.
2. The typical motionless decubitus or attitude of the patient.
4. The obliteration of liver dullness.
5. Bowel sounds will be absent.

For the patient who has an ulcer history the above findings are diagnostic. For the patient without an ulcer history they are still sufficiently suggestive to establish a diagnosis.

The intensity of the pain is explained by the irritating nature of the escaping acid gastric contents and their effects on the most sensitive surfaces in the body. Of all the serous surfaces the parietal peritoneum is said to be the most sensitive, more so than pleura, pericardium, even meninges. The diaphragmatic peritoneum is the most sensitive portion of the parietal peritoneum.

The escape of air or any foreign fluid into the peritoneal cavity causes pain. A mixture of gastric juice, bile, pancreatic juice and succus entericus creates a most potent and painful influence when it comes in contact with this sensitive parietal peritoneum. Hence the extreme pain and characteristic rigidity. The sensory muscle endings are not accustomed to this insult and abdominal muscles respond by reflex contraction to an exaggerated degree in proportion to the irritation created by the irritating agent. The peritonitis which occurs in the first six or eight hours is a chemical peritonitis rather than a bacterial

atures during this period are usually sterile. Free air may be demonstrated by percussion the obliteration of liver dullness. For many clinicians had to depend on this observation. The X-ray provides a more reliable estimation. A plain plate is made with the patient lying on his left side and one in the sitting position. A positive X-ray demonstration of free air is diagnostic of perforation. A negative finding does not necessarily eliminate it. We find that free air can be demonstrated in from seventy to eighty per cent of the cases.

All diagnosed cases should be immediately operated and prepared for operation. For those requiring transportation delay is not to be tolerated. A hypo, not less than morphine grs.  $\frac{1}{4}$ , may be given. If the circumstances permit, an swelling Levine tube may be inserted to aspirate stomach contents before transportation is undertaken. It is well to remember that early cases become late cases within forty-eight hours and unwarranted delay is not excusable.

Late symptoms are those of general peritonitis the penalty of delay. The prognosis is grave at this time. Suffice it here to say that with the onset of peritonitis the temperature and leucocyte count increase in degrees, commensurate with the reaction of the patient to his toxæmia, the site of perforation and the condition of the stomach when perforation occurs. Gastric perforations with full stomach allow for gross soiling and there may be an accumulation of fluid in the flanks, particularly the right flank, very early in the catastrophe. Unless the patient is moribund obviously a bad surgical risk, he should not be deprived of the benefit that surgical treatment may offer even in the delayed cases.

#### Differential Diagnosis

For those cases which present a typical history, diagnosis is relatively easy, especially if it can be confined by the presence of a pneumoperitoneum. In the less typical cases, it may be necessary to exclude:

- Acute pancreatitis.
  - Coronary thrombosis.
  - Acute spasm of the colon at the splenic flexure.
  - Strangulation of a diaphragmatic hernia.
  - Acute perforation of the appendix—especially if the appendix is higher than normal as in non-perforation of the caecum.
  - Acute perforation of the gall bladder.
- I have made a mistaken diagnosis in both of the latter two instances. The appendix case did come to operation early and he died of a general peritonitis. The gall bladder case, a police-trial, recovered.

Time will not permit a detailed discussion of differential diagnosis—so we will pass on to treatment.

#### Treatment

Within the past three to five years there has developed a wide spread of ideas from the formerly accepted treatment for acute perforation. This spread is from one of ultra-conservatism to that of ultra-radicalism. Both are championed by experienced and reliable clinicians. Admittedly both have a place in the treatment.

There does exist, however, some confusion in the minds of medical men as to which form of treatment one should adopt. Formerly we were not worried about alternative methods in the management of these cases, for the universally accepted view was that only one method existed; viz., surgical.

Today we are confronted with three alternatives.

1. Non-surgical management, and the pinning of our faith on continuous aspiration and decompression by an indwelling gastric tube.
2. Emergency operation and simple closure of the perforation, supported before and after operation by gastric suction.
3. Primary gastric resection at the time of the emergency operation.

Perhaps all three have a place but it is my personal opinion that the place of the older well-established method; viz., simple closure far exceeds the other two, and it is the safest method to teach.

To eliminate the third gastric resection as an emergency method first; it is indicated only in early cases before the onset of peritonitis. It is a job that should be undertaken only by the expert gastric surgeon under ideal circumstances—working with his trained assistants in a modern well-equipped hospital with the services of a competent anaesthetist. Special indications are—perforation of a malignant ulcer—perforation in those cases who have a previous history of haemorrhage and perhaps in some cases of large gastric perforations.

If you agree with me in these criteria, it is obvious that the place for emergency gastric resections must be relegated to a very small percentage of cases.

One argument advanced for resection is a formerly accepted view (perforation cures the ulcer) has long since exploded. I believe, as a result of follow-ups in my cases, that it does relieve about thirty-five per cent of the cases, certainly for periods up to five or more years. I personally would rather not belong to the thirty or thirty-five per cent who had been subjected to an unnecessary gastrectomy as an emergency procedure.

Prof. Illingworth in his recently published textbook states that their follow-up records in a large series of cases confirm our findings in a much smaller series, viz. that about 35% of cases are



permanently relieved of ulcer symptoms following successful closure of acute perforation.

I think this particularly applies to the problem which we are presently discussing. Our formerly accepted treatment is easily accomplished and is within the scope of even the occasional surgeon. For early cases operated upon within six to twelve hours in a modern hospital with modern facilities, the mortality rate need not exceed from two to five per cent. In late cases where peritonitis is already established, neither treatment is going to produce desired results. If a choice is to be made, surgery has the advantage.

Recently I read an article comparing the non-surgical with the surgical treatment using records of approximately one hundred cases of each. The results compared favourably but I noticed the average age in the non-surgical group was much younger—only thirty per cent were forty years or older whereas in the surgically treated series seventy-four per cent were forty years of age or older—thirty patients were in the age group of fifty to fifty-nine—eighteen were sixty to sixty-nine and six patients seventy to seventy-nine, a significant observation. It is obvious that in this series, the surgically treated cases contained a great preponderance of the poorer risk patients.

Be that as it may it is not my purpose to champion any one method of treatment. You are all capable of choosing for yourselves. It is, however, my definite impression that for the average surgeon under ordinary circumstances

the safest procedure to adopt is simple closure. In virtue of the reported results from various sections of the country for non-surgical treatment I feel that the time has arrived for an unbiased assessment of the advantages or disadvantages which rightfully belong to each method.

As one of the older groups of surgeons I have always regarded the adoption of the non-surgical treatment with scepticism. I would be slow to change a proven form of treatment which has long since been established by a simple surgical procedure and which has produced such satisfactory results.

My arguments against the non-surgical continuous decompression or suction method are:

1. It requires constant vigilance for from 5 days by trained personnel—24 hours a day—hospitals can provide this type of individual care.
2. There is no accurate way by which we can determine where the perforation is healing or perhaps whether it even existed.
3. How can one determine whether it is gastric or duodenal?—small or large?
4. How can we estimate the amount of leakage which has occurred and the degree of soiling before treatment was instituted?
5. The complications must be increased with the collections of escaped juices—food particles, etc., are left within the peritoneal cavity.
6. Is this form of treatment applicable to all cases?

## Paediatrics

### Diarrhoea in Childhood\*

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Diarrhoea is commonest in 1st year of life and is frequently associated with vomiting. In the main death rate is lower in the breast fed infant. It remains an important cause of death up to the age of 5 years.

#### Aetiology

**Dietetic**—Overfeeding and underfeeding—far more frequently quantitative than qualitative.

Carbohydrate excess.

Fat excess.

Later childhood an orgy of fruit or candy.

Drugs—Aureomycin, Terramycin, etc.

**Parenteral Infection**—An important cause especially in the U.K.—otitis media, pyelitis or any constitutional infection—lungs and meningococcal meningitis. Beware of appendicitis in children—irritation caused by the inflammation may cause diarrhoea—this in contrast to adults who very rarely have appendicitis with diarrhoea. Appendix

abscess may form very quickly. Peritonitis may result from any cause.

**Enteric Infection**—Highest in late summer and autumn. Can be rapidly severe—few hours.

Specific—Sonne Dysentery giving rise to blood and mucus in the stools. B. Coli dysentery, Staphylococci, Streptococci, Typhoid, Salmonella, etc., can under certain circumstances become pathogenic.

Non-Specific—Epidemics in Winnipeg every 10 years. Fall and Spring usually accompanied by vomiting and fever. This may be a virus infection.

**Chronic Diarrhoea**—1. Parenteral infection. 2. Inadequately treated diarrhoea—in infants especially, there is tendency once having had an attack for recurrence. In very severe cases duration is frequently one of 3-4 weeks no matter what the treatment. Milk and fruit easily cause recurrence.

3. Fibrocystic disease of the Pancreas—associated with wasting, chest infections including abscess formation. Often familial, child has good appetite. Diagnosis is made on the absence

\*Notes from a Lecture to Portage la Prairie Section of Manitoba Medical Association, December 14th, 1953.



trypsin in the duodenal juice—stool trypsin is unavailable.

4. Malformations of the gut—redundant sigmoid, fistulae, spurious diarrhoea of Hirschprung's disease.

5. Coeliac Syndrome—age 9 months to 2 years. Not familial, child very miserable, wasting particularly of thighs and buttocks, pot belly. Stools contain excess of fat and often starch granules. At one time divided into starch intolerance and fat intolerance. Quantitative fat estimations can be made. Very difficult to prove, but tests include glucose tolerance curves, Vitamin A absorption tests, X-rays with Barium showing clumping into pellets instead of normal feathery pattern.

Complications—Anaemia, Oedema, Purpura, Rickets.

The recent work on this disease makes a fascinating study. Workers in Holland noticed that Coeliac Disease practically disappeared during the German occupation. At this time cereals were scarce and people used soya flour. British workers at Birmingham then set out to show what specific factor could be incriminated. They found it to be the gluten factor in wheat or rye—NOT STARCH.

6. Giardia Llamblia infestation may occur in residential nurseries, and responds promptly to Atebrin.

7. Tuberculosis, typhoid, paratyphoid infections are rare, but must be born in mind.

#### Clinical Manifestations

- Fever.
- Fontanelle depressed.
- Infant miserable and wailing.
- Urine output poor.
- Drop in weight.
- Usually accompanied by vomiting.
- Tongue dry and red.
- Abdomen flat or sunken—peristaltic movements can be seen.
- Rapid pulse.
- Albuminuria.
- Toxaemia—Face livid and pinched.
- Restlessness—apathy.
- Eyes staring.
- Heart irregular.
- Cyanosed extremities.

Complications—Thrush, Otitis Media, Broncho-Pneumonia. Skin—abscesses—very bad sign, purpura, Thrombosis of veins.

Pathology—Ulceration of bowel, Liver damage, (Beware of Hepatitis).

#### Treatment

1. Starve for 48 hours—plain water, sugar and water (1 tbs. corn syrup to 1 pint water and pinch of salt), ginger ale, etc.

2. Start with arrowroot, jello, clear soup, toast, barley cereal and later rice or cream of wheat well cooked.

3. Milk should be reserved until last—if diarrhoea has not been severe skimmed milk. If severe start with  $\frac{1}{4}$  or  $\frac{1}{2}$  strength and make up with barley water (1 tablespoon to 1 pint water, cook for  $\frac{1}{2}$  hour and strain). Farmer's wife No. 3 or DRYCO may be used. Sometimes one of the protein milks is better.

4. Drugs—Sulphonamides are specific for dysentery—it does not matter what preparation is used. Other antibiotics are important in parenteral diarrhoea.

Kaopectate, Appella apple powder, are Kaolin and Pectin—quite harmless.

There are others containing Neomycin and other antibiotics which I seldom if ever use.

Opium as Tinct. Opii mg.  $\frac{1}{8}$  for each 3 months of age may be used.

At one time purgation with castor oil and stomach wash-outs were used to rid the bowel of toxic material.

5. Subcut. injections—Saline and glucose—100-200 c.c. in each axilla. 1 c.c. of hyaluronidase at site of injection.

6. Intravenous therapy—for the dehydrated child or when diarrhoea cannot be brought under control. Give sufficient fluids to ensure excretion of catabolites, but don't push to the extreme of water intoxication.

#### Requirements

Maintenance—150 c.c. per Kg in 1st year of life per 24 hours.

100 c.c. per Kg at 5 years.

50 c.c. per Kg at 10 years.

Estimated fluid loss:

1. Amount equal to loss in weight, if this known, to be given in first 24 hours.

2. Moderately dehydrated child has lost 6% of body weight and severely dehydrated child has lost 10% of body weight. This must be made up in first 24 hours in addition to maintenance requirements.

3. After first 24 hours maintenance allowance is often sufficient, but amount lost in stools should strictly speaking be added to this.

Type of Fluids—In absence of adequate laboratory facilities where estimation of chlorides,  $\text{CO}_2$ , pH E.K.G. or K and Na amongst others can be made treatment must be by rule of thumb. Provided child is getting better and general condition is good this is quite safe, but if this is not so, child should be transferred to a hospital where facilities are available. In general remember that the dangers of overtreatment are almost as severe as undertreatment and the sooner one can begin oral fluids the safer one will be.

1. With severe diarrhoea and in the presence of signs of acidosis ( $\text{CO}_2$  less than 30 Vols.%) it may be wise to start with a sodium chloride + 6 molar lactate solution in the proportions of 1 to 1.

Acidosis occurs in dehydration and symptoms include hyperpnoea, headache, nausea, drowsiness.

2. Saline—the safe proportions for maintenance in a child is 1 part of Saline to 5 parts of glucose and water (1/5 Normal Saline). In the early stages when it is felt that NaCl loss has been high it is usual to start with one part of Saline to 2 parts glucose and water.

Requirements  $\frac{1}{2}$  gms.—2 gm. daily NaCl.

3. Proteins should be given as plasma or whole blood after the initial fluid loss has been made up. Intravenous amino-acids on the whole have proved disappointing. The quantity should be 10 c.c. per lb. of body weight.

4. Potassium—once the child is voiding freely potassium should be given. This is usually given as Darrow's Solution. (K 2 gms. Na 3 gms. in 750 c.c. of solution).

For hydration about 80 c.c. per Kg of the total fluid requirements is given each 24 hours. 1 part

of Darrow's to 2 to 3 parts of glucose and for maintenance (20-40 c.c./Kilo). Never exceed 70 MEq/litre of potassium (0.5% K Cl). Do not exceed 4 c.c./minute of this solution.

5. Calories—for long term cases in order to provide sufficient calories 10% invert sugar is instead of 5% glucose and water.

6. Paracentesis of Drums—may be necessary in the presence of prolonged diarrhoea when drum is mainly red or swollen.

### Summary

Diarrhoea particularly in infancy can be a serious disease and requires prompt action in diagnosis and treatment. Early adequate treatment may avoid the more complex treatment when the case progresses. In any case of chronic diarrhoea always search for parenteral or enteric infection.

### Reference

W. Sheldon et al, *Lancet*, 1952, 11: 902. The Management of Coeliac Disease.

## Tuberculosis

### An Investigation of Concentration Techniques for the Cultivation of *M. Tuberculosis*

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Various techniques for isolation of *M. tuberculosis* from contaminated materials such as sputum, gastric washings, urine or ascitic fluid have not proved altogether satisfactory. A procedure utilizing NaOH digestion followed by centrifugation and culture of the sediment is now generally practiced and is the method followed in the Department of Bacteriology of the Winnipeg General Hospital.

Silverstolpe (3) determined that the specific gravity of *M. tuberculosis* might vary from 1.07 to 0.79, with an average value of less than 1.0. Baldwin (1) estimated a variation of 1.004 to 1.037 in the specific gravity of sputum. The specific gravity of 4% NaOH is 1.04. These figures indicate that the specific gravity of *M. tuberculosis* in sputum digested with NaOH may be well below that of the suspending fluid. Therefore during centrifugation of such digested sputum one might anticipate that the bacilli might rise, with possible subsequent recovery of the organism from the surface of the supernatant.

Recent investigation (2) has demonstrated that the practice of centrifuging digested sputum for a period of 15 minutes at 3000 r.p.m. is not an especially effective method for the concentration of *M. tuberculosis*.

Klein et al (2) obtained positive cultures from the surface of centrifuged digested sputum in 88.8

per cent of one series of experiments and in 75 per cent of another series. In 2.7 per cent of a third series and in 2.2 per cent of a second series of surface cultures were obtained from the surface of the supernatant when no growth was obtained from the culture of the sediment. These workers conclude that as in some instances the specific gravity of the bacilli is less than that of the digested sputum, cultures should therefore be prepared from the surface as well as from the sediment of the sample.

The purpose of this investigation was to evaluate the method presently in use in the Department of Bacteriology, Winnipeg General Hospital to test the efficacy of other recommended methods. The investigation may be outlined as follows:

1. To test the efficiency of the present method, using material known to contain tubercle bacilli.

2. To test and evaluate the effect of various concentrations of the synthetic detergents, Triton 80 and Ultrawet 60L on the sedimentation of *M. tuberculosis* in sputum digested with 4 per cent NaOH.

3. To study the effect of glycerol when added to NaOH digested sputum on the separation of *M. tuberculosis*.

4. To compare the relative value of centrifugation of digested sputum at 2000 r.p.m. for 15 minutes, with a rate of 10,000 r.p.m. for 20 minutes on the sedimentation of *M. tuberculosis*.

### Materials

Tuberculous sputum when obtainable, was used in all tests, otherwise a suspension of a stock culture of *M. tuberculosis* was substituted. Sediment was supplied by the Central Tuberculosis

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and the King Edward Hospital, both located in Winnipeg. The synthetic detergents, Tween 80 and Ultrawet 60L were donated by the Atlas Powder Company.

All samples were homogenized in a "Waring Blendor" placed for safety in a glass covered ultra violet cage.

An International centrifuge with high speed attachment was used for all separations.

Sterilized glass 50 ml centrifuge tubes were used for centrifuging at rates of 2000 r.p.m.; for rate of 10,000 r.p.m. sterilized plastic cups were substituted. (The plastic cups were sterilized by baking in formol or Dettol solution, followed by thorough washing with distilled water, and a final 24 hour exposure to ultra violet light.

All samples were planted on Petragnani's medium.

### Procedure

A volume of tuberculous sputum, or alternatively a saline suspension of *M. tuberculosis* was placed in a Waring Blendor with an equal volume of 4 per cent NaOH. In order to prevent possible droplet contamination of the laboratory, all homogenizations were carried out in a glass covered ultra violet light cage for a period of two minutes, followed by digestion of the sample in 4 per cent NaOH for 20 minutes. At the end of this period, five drops of methyl orange indicator were added to the specimen, followed by neutralization with per cent HCl.

Four separate tests were prepared for each experiment as outlined in Table I.

Table I

	Bacterial suspension	Sterile water	16% Tween 80	1.6% Tween 80	Glycerol
e 1	15 ml	5 ml	---	---	---
e 2	15 ml	---	5 ml	---	---
e 3	15 ml	---	---	5 ml	---
e 4	15 ml	---	---	---	5 ml

An equal concentration of bacilli in solutions (1) sterile H<sub>2</sub>O (2) Tween 80, 4 per cent (3) Tween 80, 0.4 per cent and (4) glycerol 25 per cent was obtained.

The four members in each test were designated a series, with each member comparable to each of the other members. When a sufficient volume of material was available several series were prepared; some of which were centrifuged at a rate of 2000 r.p.m. and some at 10,000 r.p.m.

Following centrifugation four cultures were prepared from each member of a series, a total of 16 cultures being required for each series. A procedure was established for the inoculation of cultures; with a sterilized 5 ml pipette, 1.5 ml was withdrawn from the surface of a sample and two tubes of Petragnani's medium inoculated

with 0.5 ml of the fluid, the remaining fluid in the pipette being discarded.

These cultures were marked respectively "Top 1" and "Top 2." Using the same pipette all but 1.5 ml of the remaining supernatant was removed and discarded.

One ml of the residue in the tube was then withdrawn with a sterile 1 ml pipette and 0.5 ml amounts inoculated into two tubes of Petragnani's medium. These second cultures were marked "Sediment 1" and "Sediment 2". Throughout the investigation this method was used for the inoculation of each member of a series.

By trial it was found that more accurate quantities could be removed from a tube by using a 10 ml syringe attached by a short length of rubber tubing to a pipette in place of the more conventional pipette with attached rubber bulb.

All cultures were slanted and incubated at 37°C for 6 weeks with the first examination of the cultures at the 3rd week and repeated on the 4th, 5th and 6th week of incubation. Colonies were counted by direct vision, but when growth was too profuse such a culture was reported as "loaded." Forty-three series were tested in all.

### Results

A summary of results is shown in Tables II and III.

Table II

Comparison of Cultures from Supernatant and Sediment, Specimens Centrifuged at 2,000 r.p.m. for 20 Minutes

Method	Total No. of Series	Supernatant Best	Sediment Best	Supernatant and Sediment Equal	No. of Series Negative	Results Equivocal
Control	25	2	13	1	6	3
4.0% Tween 80	25	2	12	0	8	3
0.4% Tween 80	25	3	11	1	7	3
25% Glycerol	25	3	9	1	9	3

Table III

Comparison of Cultures from Supernatant and Sediment, Specimens Centrifuged at 10,000 r.p.m. for 20 Minutes

Method	Total No. of Series	Supernatant Best	Sediment Best	Supernatant and Sediment Equal	No. of Series Negative	Results Equivocal
Control	18	2	11	0	4	1
4.0% Tween 80	18	4	10	0	4	0
0.4% Tween 80	18	3	11	0	4	0
25% Glycerol	18	2	9	3	4	0

Footnote—All samples of sputum were positive for acid fast bacilli on smear. The 26% of negative cultures may be due to the effect of streptomycin which a number of the patients were receiving.

### Summary

From Tables II and III it is evident that the ratio of "sediment best" cultures to "supernatant best" cultures was not altered significantly by using different methods of concentration, i.e. Tween 80, glycerol or high speed centrifugation.



The results from all methods of concentration may therefore be grouped together to make the following observations on a total of 172 cultures. Cultures from the sediment and supernatant were both positive in 50.5 per cent of the specimens. Bacilli were recovered in 50.0 per cent of cultures in a higher concentration from the sediment than from the supernatant. In 11.6 per cent of cultures the supernatant yielded a higher concentration of bacilli than the sediment. Ten and one-half per cent of cultures were positive from the supernatant when cultures from the sediment were negative. An important observation was that of the 21 cultures which showed a greater number of bacilli in the supernatant by one method of concentration, 14 showed a greater number of bacilli in the supernatant by all methods of concentration.

This suggests that sedimentation of tubercle bacilli is more dependent upon variations in the specific gravity of the tubercle bacilli and suspending medium than upon the actual technique of concentrations.

### Conclusions

Tubercle bacilli are not always sedimented during centrifugation of clinical samples; the bacilli sometimes rise to the surface, probably due

to variations in the specific gravity of the organisms and suspending medium.

The Concentration techniques used in this project, i.e. Tween 80, glycerol, high speed centrifugation, were no more efficient in the separation of tubercle bacilli than the technique utilizing NaOH digestion and centrifugation at 2000 r.p.m. for 20 minutes.

In order to improve the efficiency of existing techniques, cultures should be made from the surface of the supernatant fluid as well as from the sediment.

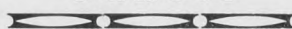
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## Cancer



### Cancer of the Lung

In Canada as in many other countries, cancer of the lung seems to be the only form of cancer to have shown an increase which cannot be explained by the general ageing of our population. In 1935 lung cancer accounted for 2.4% of cancer deaths while in 1949 the latest year for which comparable Canadian figures are available, this had increased to 4.2%. Just how much of this increase is apparent and how much is real are difficult questions to answer.

It must be remembered, in seeking a possible explanation of this phenomenon, that over the same period of time, medical science has made a number of advances which help to increase the accuracy of diagnosis of lung disease, including cancer.

The bronchoscope, an instrument for looking into the main air passages of the lung is now used routinely. In expert hands, the examination of sputum for malignant cells will give positive findings in three out of four lung cancer cases. There has also been a vast improvement in the radiological diagnosis of lung diseases. Again, the opening of the chest surgically to explore suspicious and unexplained disease is now a procedure not at all

uncommon and one associated with relatively little risk to the patient. It might be expected, therefore, that with these new diagnostic measures a specific diagnosis of cancer of the lung is being made more frequently than it would have been thirty years ago.

Moreover, doctors are now more aware of the possibility of lung cancer being a cause of chronic lung disease and it is possible that this diagnosis rather than pneumonia, chronic bronchitis and emphysema, is being placed on death certificates more frequently. Again, in only a little more than half of cases is the diagnosis proven by microscopic examination of tissues, so the accuracy of reports may always be questioned.

On the other hand it has been the experience of our larger hospitals that cancer of the lung has definitely increased. This is an observation supported by a post-mortem findings and the review of cases in which a diagnosis of lung cancer might have been missed.

Be these facts as they may, a number of factors have been incriminated as possible agents in the development of lung cancer.

For several hundred years miners in Saxony and Joachimstaal, in eastern Germany and Czechoslovakia, have succumbed to chest disease the nature of which was not fully understood

century when it was shown to be cancer of the lung. Cancer of the lung occurs in about 80% of miners of Schneeberg and 50% of the uranium miners of Joachimstaal. Although complete evidence is still lacking it would seem that radioactive-gases are responsible.

On several occasions in recent years the chief inspector of factories in England has mentioned the appearance of cancer of the lungs in workers exposed to the inhalation of the dusts and fumes of arsenic.

Since 1932 it has been known that workers in the chromate industry may have a high incidence of cancer of the lung. A recent study of several chromate industries in the United States showed that lung cancer occurred almost 25 times as frequently among male employees as among the general male population.

Again, some 25 cases of lung cancer associated with asbestos disease of the lung have also been reported, suggesting that there may be a relationship between asbestos and lung cancer.

In 1932, from South Wales it was reported that there was a high incidence of cancer of the nasal sinuses and lungs in men who refined nickel ore using the nickel-carbonyl process.

Japanese doctors in 1936 reported that there was a high incidence of lung cancer among stokers exposed to the inhalation of hot tar fumes in a Japanese generator plant. Furthermore, there is some experimental evidence that soot obtained from gasoline motor exhaust products and from atmospheric dust may, in mice and rats, induce cancer of the lung after inhalation, or cancer of the subcutaneous tissues after injection.

Another observation worth noting is that deaths from cancer of the lung appear to be more frequent in urban than in rural areas, suggesting that smoke, industrial wastes, the fumes from motor vehicles or factors unknown may be related to lung cancer.

And now, during the past few years studies indicate that tobacco may play a part in the pro-

duction of lung cancer. Investigations in the United States, Great Britain and Scandinavia would seem to show that patients with lung cancer are more likely to be smokers and that these patients have smoked more heavily and for a longer period than comparable groups without lung cancer. The possibility that arsenic in the cigarettes may be a causative factor has been investigated but no correlation has been found between the arsenic content of the tobacco of several western countries and the increase in the mortality rate from lung cancer in these countries. More recently, research workers in the United States have collected the tar from burning tobacco and with it have produced cancer of the skin in mice. However, those familiar with cancer research know that what happens to a certain strain of mice may not happen to another strain of mice, and any scientist would be loth to infer that a substance which causes cancer of the skin in mice necessarily causes cancer of the lung in humans.

It is not our intention to belittle the evidence for a relationship between lung cancer and smoking for the evidence in fact, points in that direction but we would be unwise to lose our sense of perspective at this time.

We must remember that lung cancer causes only about one in every two hundred Canadian deaths and we cannot be sure how much of the reported increase in death rates from lung cancer is apparent and how much is real. The National Cancer Institute has given support to three Canadian research projects related to lung cancer. It is to the credit of the tobacco industry that it is embarking upon a research programme to learn more about the possible effects of smoking on bodily health.

Research workers in this and other countries are concerned with a number of factors relating to lung cancer and developments in this field over the next ten years will be of great interest.

## Dermatology

### Ringworm in Rural Manitoba

A. R. Birt, M.D., J. C. Wilt, M.D.

and

Miss E. Hirst, B.Sc.

During the past year the authors have had a Public Health Grant\* obtained through the Province of Manitoba, to survey certain aspects of the problem of suppurative ringworm in this province. In an endeavor to obtain as complete a picture of its prevalence as possible, the co-operation of all physicians practicing in rural Manitoba is sought. If specimens from patients suspected of having pustular ringworm, are taken in the method described in this article and sent to Dr. J. C. Wilt, Department of Bacteriology, Winnipeg General Hospital, reports will be forwarded to the doctor without charge. Your co-operation in this study will be appreciated.

For all practical purposes, the only kind of ringworm found in rural Manitoba is suppurative ringworm. Humans usually develop the condition following exposure to infected cattle.

Suppurative ringworm has a very definite seasonal incidence in this province; the vast majority of cases occur from January to May. Cattle develop ringworm during the cold winter months when they are confined in close quarters in barns. It is at this time that most of the human infections occur.

Clinically, suppurative ringworm is characterized by nodules or large boggy masses that arise abruptly from the surrounding tissue. They are angry red in color and are dotted over with perifollicular abscesses. The hairs in these follicles are either lustreless and broken, or shed completely, leaving gaping holes containing purulent fluid. The lesions are known by various terms depending on the site of the human body that is infected. If the scalp is infected the lesion is known as Kerion celsi; if the beard area is involved the diagnosis is Sycosis parasitaria or Tinea barbae; and if the glabrous skin is affected the terms used are Agminate folliculitis or Tinea profunda. Irrespective of the names applied, all the lesions have the same clinical characteristics and only vary because of their location on the skin.

Suppurative ringworm, contracted from cattle in Manitoba is caused by either *Trichophyton mentagrophytes* (gypseum) or *Trichophyton faviforme* (album). The diagnosis of ringworm can be

proven by demonstrating the fungus in the hairs, and by establishing its identity by cultural methods. It is very important to take great care in selecting hairs for examination, as it is of no use that only infected hairs will show the presence of fungi. The best hairs for examination are lustreless, white looking, broken ones, that are extracted easily, or hairs covered with crusts centred in pustules.

Filtered ultra-violet light is of no value in selecting the specimens. The hairs can be removed with a small pair of inexpensive epilation forceps and placed between two clean, dry microscope slides. The name and relative information such as the age of the patient and site of the lesion is then written on a slip of paper, wrapped around the slides, and held in place with an elastic band. This specimen can then be sent to the laboratory for microscopic and cultural examination. Reports on the microscopic examination are available within 24 hours after arrival of the specimen at the laboratory. The culture may take up to four weeks.

The treatment of suppurative ringworm is a tedious one. It should be made clear to the patient at the time the diagnosis is confirmed, that at present there is no rapid method of cure of the human body, through an allergic mechanism, induces suppuration with resultant shedding of infected hairs, and eventual healing of the lesions. This process may take two or three months, if not interfered with, will probably leave little scarring. The pus found in ringworm is of bacterial origin. There is therefore no scientific rationale for using antibiotics in the treatment of this condition. As these drugs are both expensive and apt to carry with them the possibility of severe adverse reactions, it would seem wise to use them in the treatment of ringworm.

Strong applications that may produce severe reactions are to be avoided as they produce scarring. The best results are obtained by conservative therapy such as boracic acid poultices and ammoniated mercury ointment. Manual epilation of hairs in pustules may shorten the course of the disease. X-ray epilation is not indicated. Some authors believe, however, that small doses of superficial X-ray will hasten the resolution of nodular lesions. It is important to remember that the disease is self-limited in its course; that present day treatment does not shorten the course of the disease; and that the use of antibiotics and strong local applications is to be avoided.

\*A preliminary report on this work is to be published soon in the Archives of Dermatology and Syphilology.



# Children's Hospital, Winnipeg

## Ward Rounds

Edited by Wallace Grant, M.D.

### Tuberculosis of the Knee Joint

Case No. A-486\*

This is an eight-year-old boy admitted on January 11th. From April, 1953, until August he complained intermittently of pain in his right knee. At that time, because nothing could be seen that was unusual about the knee, the complaints were disregarded. The pain lasted for two or three minutes, and occasionally during these episodes he would have a slight limp. In August his right knee began to swell slightly without any evidence of bruising, or history of trauma. He was then able to flex and extend his knee through the normal range. Since that time the knee has remained swollen. Sometimes the swelling receded slightly, but it never completely disappeared. The knee has been continuously painful since August unless it were completely at rest. Early in December the knee became stiff quite suddenly but it has not become much stiffer in the interim. He was admitted to a rural hospital for study and remained there from December 4th to the 15th. He had no medication before his admission or after discharge from hospital, and the mother does not know what was done for him there. There was, however, little change in his condition after leaving the hospital, so he was referred here on January 9th.

There have been no illnesses in the past except occasional colds and measles in 1952. In the family history the only possibly significant disease has been in an aunt who has tuberculosis, although there is no known tuberculosis in his immediate environment. The family uses canned milk most of the time, but occasionally they use raw cow's milk, especially in the summer, and these cows are tuberculin tested.

On examination at admission, there was nothing unusual found except in the area of the right knee which was markedly swollen with slightly increased heat and it was difficult to detect the presence of fluid. The joint could be moved only from flexion of 45 degrees to 80 degrees. There was tenderness on light pressure. There was rather definite wasting of the right thigh and right calf. Temperature was normal. The white cell count was 13,500 with a normal differential, the hemoglobin was 14.5 grams per 100 c.c. and the erythrocyte sedimentation rate was 18 mm. per hour. Urinalysis was normal. On January 4th the right knee was aspirated under local anaesthetic and one c.c. of thick yellow pus was taken off which was sent for a guinea pig inocula-



tion, smear, and culture. Examination of the smear revealed no organisms, but many pus cells. Culture on blood plate had produced no growth in two days. Tuberculin patch, and intracutaneous tuberculin (1 per 1,000) were both reported as definitely positive in two days.

**Dr. Childe:** We just X-rayed one knee. There was a good deal of soft tissue swelling and we thought there was probably excess fluid or some material within the joint. The joint space, particularly laterally, was narrowed. The articular surfaces were somewhat irregular. The bones were demineralized and I suspect that if we had done the other knee we might have found that these epiphyseal centers were a bit over-grown. There are, of course, various things that could give this appearance but it seemed that, without knowing too much about him, the first choice should be tuberculosis, although we haven't seen any tuberculous knees for some time. The chest film shows no convincing evidence of pulmonary tuberculosis.

**Dr. Welply:** This boy clinically shows a large generalized swelling of the knee with a slight amount of fluid in the joint, but with very marked muscle wasting. This is very characteristic of tuberculosis, you get more wasting than you'd think could be due solely to that amount of disuse, and more than with any other arthritis of the knee joint.

Although, as Dr. Childe says, this is now a relatively rare condition here, there are parts of the world where it is still fairly common, and during the three years I worked in China, I must have seen 30 or 40 cases. Probably the most satisfactory way of confirming the diagnosis is by lymph gland biopsy. In every case it will show the changes typical of tuberculosis if the condition has been of any duration. The lymph node was removed in this case from alongside the femoral vessels, and Dr. Hoogstraten's report confirms the diagnosis, although he has been unable to demonstrate any tubercle bacilli.

As to treatment, I haven't used isonicotinic acid hydrazide except in a case of tuberculosis of the wrist, where the infection completely cleared up

\*Case presented at Ward Rounds on January 21, 1954.

except that the bony changes have not particularly altered. That young lady of 22 has now a perfect working hand without any disadvantages whatever. I think this child should be treated with streptomycin and isonicotinic acid hydrazide, and I think you will find most of his symptoms and signs will clear up. However, I think that considering the bony changes already present, he will get a fibrous ankylosis and will not have a fully working knee.

If you get them earlier, when there is still only synovial involvement, there will be complete recovery with a return of full function with streptomycin alone, at least that was my experience in China.

**Dr. Medovy:** Do you think it would be worthwhile to use hydrocortone into the knee along with the drugs you have mentioned, with the idea of minimizing fibrous changes and perhaps, in the end, getting a better result?

**Dr. Welply:** Of course hydrocortone is not used if there is infection in a joint, it seems on occasion to spread the infection . . .

**Dr. Medovy:** Yes, but recently it has been used in tuberculous meningitis, and as long as the patient is well under antibiotic control the hydrocortone seems to minimize fibrosis.

**Dr. Welply:** In that case it would probably work quite adequately.

**Dr. Childe:** You would say that the cartilage is probably in very poor condition?

**Dr. Welply:** Very poor, he has had about a year's history, and he already has a fair amount of flexion contracture. He is in traction now to pull his leg out straight.

**Dr. Childe:** The lymph node is from the groin?

**Dr. Welply:** Yes, in a case like this, the lymph node must not be a superficial inguinal node, but must be from the group alongside the femoral vessels. We have always found the biopsy to be positive.

**Dr. Merkeley:** What happens now about tracking down the source of infection?

**Dr. Chown:** We know only of possible exposure to an aunt who had tuberculosis, and the child has also had raw milk. We have asked Miss Norris to try to determine whether or not this is a human or bovine type of tubercle bacillus.

**Dr. Welply:** Many text books state that this type of infection is usually due to bovine tuberculosis, but all the ones we had in China proved to be the human type (of course they don't drink much milk in China).

**Dr. Briggs:** This has been borne out in England, where, in spite of common opinion to the contrary, it has been shown that a large number of cases of bone and joint tuberculosis, as well as tuberculous glands in the neck, are due to the human type of tubercle.

**Dr. Welply:** Another point about knee tuberculosis is that the disease process commonly begins in the synovial membrane, whereas in other joints it commonly starts in the bone.

**Dr. Childe:** Our experience in Quebec was many of these knees show no bony change, but cartilage destruction for a long, long time.

**Dr. Welply:** Those are the ones that do not progress to ankylosis.

**Dr. McLandress:** Do you think that the result in this case would be better if Dr. Medovy's suggestion were followed, that hydrocortone should be used along with the antibiotics, I.N.H.?

**Dr. Welply:** I think it's a good suggestion, though I feel we should have him on streptomycin for a time first. This might prevent him getting a fibrous ankylosis but should it occur he would eventually need an operation to produce a functional joint. If this is not done, there is apt to be a recurrence of the infection in the knee, presumably due to the fact that the fibrous tissue becomes torn and tubercle bacilli are released. If you do a bony fusion, the patient is usually cured once and for all, but he is still a little young for this procedure. The longer you can avoid surgery in the neighbourhood of his epiphysis while he is growing, the better length of leg he will have in the end. As Dr. Childe has also pointed out, this leg, at the moment, appears to be a little longer than the other one although it is hard to measure with his knee flexed.

**Dr. Childe:** Even if you do not get fibrous ankylosis, with the loss of cartilage he has, it is probable that even if the tuberculosis clears up he would develop pronounced changes within a comparatively short time?

**Dr. Welply:** I think he'd probably get into his thirties before he'd have many symptoms due to the degenerative changes and if you can keep him going as long as that, it's worthwhile. With a tuberculous knee, we usually do the operation right away, fusing the joint so that they go back to work as soon as possible. The six other cases of a tuberculous knee that I have seen in Canada was in a man whom I saw last year who had had trouble for two years, and by that time had a lot of cartilage destruction. Diagnosis was confirmed in that case by joint biopsy. I used the Charnley compression arthrodesis method, a pin through the end of each bone, joined by a side clamp, so that you can put pressure on the bone ends. Ten days after the operation he was able to lift his leg up and down in the air without any other support or plaster. This operation was done in June and he was back on the farm, with the joint healed, by October.

**Dr. Hoogstraten:** The biopsy showed tuberculous lymphadenitis. I can find no acid fast bacilli, which is not unusual.

## Winnipeg General Hospital

Reported by J. W. Whiteford

On February 18th, 1954, the Winnipeg General Hospital tendered a luncheon to the medical profession of Winnipeg and vicinity and to the participants in the recent regional meeting of the National Research Council. After the luncheon, the meeting was addressed by Dr. Malcolm Brown, Professor of Medicine, Queen's University. His subject was the "Survival of Transfused Red Blood Cells in Anaemia."

Dr. Brown, who was associated with the investigation of this problem in Oxford in 1941, reviewed the various techniques which have been used to date. These included: (1) Differential agglutination developed by Winnifred Ashby over twenty years ago and used again by Mollison and others during the Second World War. This consists in the introduction into the blood stream of the anaemic patient known quantities of compatible red blood cells which are nevertheless immunologically distinct from the cells of the recipient. The subsequent survival of these cells is followed by differential agglutination of repeated samples. (2) The labelling of the Heme fraction by heavy nitrogen (Rittenberg et al). (3) Labelling by the use of radio-active iron. (4) Labelling with radio-active sodium chromate.

Dr. Brown spoke chiefly of his own experience with modifications of the Ashby technique which he has used to survey various states in which anaemia was a feature. These included carci-

nomatosis, chronic lymphatic leukemia, Hodgkin's disease, lymphosarcoma, rheumatoid arthritis, and many others. He presented evidence to suggest that the anaemia in such conditions is due to, or aggravated by, the presence of haemolytic factors. Mathematical analysis of the results indicates that at least two factors, or groups of factors, are present: (1) An exponential factor which shows random activity. (2) A linear factor which, since it produces or accentuates a straight line decay curve, is assumed to act on the mean life span of the red blood cell.

Dr. Brown emphasized that, while the evidence for the presence of such factors is now reasonably established by this broad survey, the mechanism of their action and indeed the nature of the factors remain unknown. In his opinion, further knowledge must await the coincident investigation of cases in which these factors are known to be active by a variety of parallel techniques. Correlation of the results from such investigations should yield further and more specific information. From the point of view of the practicing physician, the immediate application of this investigation to date would appear to lie in the suggestion that all anaemia developing in such conditions as noted above should not automatically be ascribed to bone marrow replacement, nutritional deficiencies, or depression of haematopoiesis,

## Obituaries

### Dr. George Edwin Bruce

Dr. George Edwin Bruce died on January 30 at his home in Swan River, Manitoba, after forty-six years of service in his community. Born in Barrie, Ontario, he came to Winnipeg with his parents as a boy, and obtained his degree in Arts from Manitoba College in 1894. After teaching School in Treherne, Emerson and Strathclair, he graduated from Manitoba College in 1901 and began practice at Swan River. In 1947 he retired, but continued to take an interest in golf and curling. He is survived by his widow, a son and daughter.

### Dr. Peter C. Robertson

Dr. Peter C. Robertson, former Mayor of The Pas, died at Brandon on Feb. 14, at the age of 81.

Born in Wingham, Ontario, he came as a boy to the Neepawa district. He was educated at Rapid City and Brandon and graduated from Manitoba Medical College in 1909. He practiced in Winnipeg, The Pas, Flin Flon and Brandon.

While at The Pas he served as chairman of the school board and was coroner and medical officer for the Department of Indian Affairs. At Flin Flon he operated a private hospital. Moving to Brandon he was district coroner from 1942 until his death.

He is survived by his widow, one brother and three sisters.



## Medico-Legal

### Medico-Legal Aspects of

#### The Relation of Trauma to Disease\*

C. E. Corrigan, B.A., M.D., F.R.C.S. (Eng.),  
F.R.C.S. (Can.)

The members of both the legal and the medical profession are at times interested in this most difficult and perplexing topic. To some of our colleagues it is a matter of greater moment than it is to others. To the doctors in their ordinary practice its significance is primarily academic, while to the lawyers in their practice its solution may be of paramount importance. I propose to discuss this subject from the focus of a surgeon who on occasion expresses his opinion to lawyers who are interested in the question from the standpoint of liability and compensation.

One may commence by questioning the definition of the terms involved, namely, what is trauma?—what is disease? In the broad sense of course, trauma is disease, as are also the immediate and remote effects of trauma, but for our present purpose we must agree on a distinction. Webster attempts to define disease in most verbose and relatively unspecific terms, while his entire exposition of trauma is, "an injury or wound." Let us accept this latter definition and agree that disease usually arises from a host of other causes, reserving, however, the possibility that trauma may occasionally be a causal factor. I find it easy to become confused in pursuing the obscure dividing line between trauma and disease but let me declare unconfusedly that it is characteristic of the nature of this problem that uncertainties abound.

The simplest exposition of our problem may be framed in the form of a triad, namely,

(a) there is no relation between trauma and certain specific diseases.

(b) there is obvious causal relationship in the case of other diseases.

(c) the relationship is uncertain.

To re-examine briefly, in the first category we note that the alleged trauma cannot possibly give rise to the disease complained of, e.g., a fall from a bicycle cannot cause measles, the minor shaking up of a pregnant woman in a car accident cannot cause a birthmark on the skin of her unborn child.

It may be noted at this point that a trauma, while having no causal relationship to a disease, may be the means of first attracting the attention of the patient or his doctor to the existence of some hitherto unsuspected pre-existing lesion. Patients

frequently refuse to accept the fortuitous revelation of the trauma in such instances, e.g.,

a patient bangs his knee and medical examination immediately afterwards reveals the presence of an established tuberculous arthritis.

In the second category of the trauma-disease relationship, the trauma as described obviously gives rise to the disease. Note that we do not say **any** trauma or **any** disease—this point will be elaborated later. e.g.,

a wound on the sole of the foot results in tetanus, lockjaw,

a head injury can give rise to intractable epilepsy,

the traumatic ablation of the glands of the thyroid may result in cretinism, diabetes, eunuchism, etc.

Here the etiological role of trauma is clearly manifest and readily determined.

It is to the third category of uncertain relationship that our attention will be specifically directed from now on. Herein lies the source of abundant misunderstanding and conjecture. We are handicapped in our judgment by the fact that no specific rules apply with constancy. Each individual case must be meticulously examined and the evidence weighed with care.

No accepted medical authority can claim to know the whole truth concerning this matter, a group of possible relationships. Medical authorities tend to complicate their writings by frequently indicating that trauma **may** be a possible cause of certain ailments—though they themselves never have actually witnessed such instances in their practice.

On the admitted basis of the uncertain relationship, claimants frequently seek heavy damages. Their claims may be based on genuine conviction or may be prompted by the possibilities of financial windfalls. Denial of these claims on medical grounds are frequently difficult to pound logically, and one is often forced to the opinion, "I think so" or "I doubt it."

Before proceeding to attempt a further analysis of this indefinite group, let us consider for a moment some of the other factors that impinge on the clinical picture. These include:

the personality of the patient,  
the influence of the patient's doctor,  
the influence of the patient's lawyer.

Firstly, the personality of the patient constitutes a most important background in any instance. We are all familiar with the stable, co-ordinated patient who has not been emotionally disturbed by his accident. His statements are forthright and usually acceptable at face value.

\*Address delivered before the Medico-Legal Society of Manitoba, Winnipeg, December, 1953.

On the other hand we occasionally see the bare faced liar or, to be more civil, the malingerer. In my experience he is an exceedingly rare bird but nevertheless one who usually reveals his falsity most patently. Between these two extremes we encounter a variety of individuals whose personalities differ in such a way as to modify their statements of fact and their attitudes to their trauma and/or disease. Some doctors, perhaps more blunt than erudite, would describe these intermediates as intermediate liars of varying degree but prudence has dictated the adoption of a more genteel nomenclature.

There are, for instance, the ordinary exaggerators—and who amongst us is not so constituted to some degree. Then there are the malignant exaggerators who purposely color their story. Another group are those who are unduly alarmed, not at their present ailments but at the prospects of the unknown future, such as an extremely prolonged convalescence or the possible development of a malignant disease—all in genuine belief. They are the sad sacks in our picture but they can usually be placated by a calmly stated outline of their prognosis.

At least two other categories must be mentioned though their designations and definitions have no universal acceptance in the medical world.

(a) The patient who exhibits a post-traumatic neurosis suffers chiefly in the emotional field rather than from his physical ailments. His symptoms are based largely on fear—fear that a return to work will injure him, fear that he can never again fulfill the requirements of his previous occupation, fear that he is permanently incapacitated. His symptoms and his fears are usually related to the area of his injuries and commonly a neurosis appears for the first time following his injury. His fears in fact constitute a disease, and the question naturally arises—does his neurosis result from his injury?

(b) Lastly, the patient may be the victim of a so-called traumatic hysteria, though I feel the adjective "traumatic" should be deleted. He differs from the neurotic just referred to, in that his feeling of incapacity and disability is not based primarily on fear relative to his accident. His complaints tend to be located elsewhere than at the anatomical site of his accident. He often has a plethora of weird unconnected complaints and if this is studied at length it will usually become evident that he has been hysterical long before he sustained his accident.

Any of you may object to the description applied above to two outstanding personality types which are frequently encountered in the field of medico-legal problems. However, let it be understood that this is a free-for-all topic as far as discussion is concerned.

Secondly, the contribution made by the patient's doctor to the clinical picture. In some instances he may induce and foster his patient's fear of his ailments—this for various reasons, some consciously and some unconsciously motivated. Not infrequently he will paint the patient an exaggerated picture of his medical future, emphasizing a long convalescence with possible permanent disability. At times he appears, and I state this guardedly, he appears to unjustifiably inform his patient that the alleged disease is the direct result of trauma and that he should therefore receive generous financial compensation. Occasionally he will utilize the disability of the trauma to investigate a concurrent but non-related ailment.

Thirdly, the contribution of the lawyer to the picture. In the interests of his client he may be a bit too prone at times to infer or agree that the disease complained of does in fact result from trauma. He may sometimes take active steps to prevent or thwart the investigation of the trauma-disease relationship, e.g., he may forbid the asking of questions by a medical examiner. He may at times also generally augment his client's mistaken belief in the severe degree of his suffering.

I trust you will agree that I have been no more critical of the legal profession than I have of our own medical profession in the above discussion.

So much for the general background to our problem. Let us now examine the various roles that may be ascribed to trauma in the production of disease within that intermediate indeterminate group of doubtfully produced diseases. In any specific malady, trauma may be imputed as

- (a) the sole cause of the disease,
- (b) to have aggravated pre-existing disease,
- (c) a precipitating factor,
- (d) the means of prolonging a convalescence.

These will be discussed in order.

1. Trauma is alleged to be the sole cause of the disease in question. In order to establish a likely or probable causal relationship, the following essential postulates have been in general agreed to,

- (a) The trauma must be adequate in severity and appropriate in location,
- (b) Pre-existing normalcy must be established—in reference to the disease in question,
- (c) The post-traumatic history must be appropriate,
- (d) The disease is one which has been known to arise from trauma on occasion,
- (e) The diagnosis of the disease must be adequately confirmed by laboratory methods,

(f) It would be desirable to note that the alleged disease occurs more frequently in those groups of people who are exposed to an over-average accident rate.

Some of the diseases in question include appendicitis, peptic ulcer, tumors, tuberculosis, heart disease and goitre. In order to test the mechanism of assessment as outlined above, let us examine two of these conditions on the six-postulate-grid.

Appendicitis normally arises spontaneously by the organ becoming infected. But occasional claims for a traumatic origin are pressed. In theory such is possible, **provided**,

(a) The trauma is severe and is directed to the front of the abdomen—not necessarily in the region of the appendix,

(b) There should be no history of previous attacks,

(c) The symptoms of appendicitis should appear immediately following the receipt of the injury,

(d) Microscopic examination of the removed appendix must reveal signs of acute inflammation.

In the case of tumors, we would expect a different pattern. Strictly speaking, tumors are defined as arising by unknown origin. In theory they should not enter our problem but occasionally it happens that trauma may be responsible for their appearance—but only in certain restricted sites and when they are formed of certain specific structures. Thus,

(a) The trauma must be of minimal degree and repeated constantly to the very spot where the tumor develops. It must continue to operate over a period of many months,

(b) There must be no pre-existing ailment either in the form of local degeneration or of generalized disturbances,

(c) A long period of time, months or years, must elapse between the beginning of the trauma and the appearance of the tumor,

(d) The site of the tumor and its tissue or origin must conform to presently acceptable regions for malignant development,

(e) Microscopic examination of the tumor must reveal malignant cells of the appropriate type,

(f) Certain specific traumas are associated with certain specific malignancies.

Having examined the evidence in this fashion, one must then attempt to arrive at a decision. The answer may be far from clear but I do feel that the postulates are of some assistance in obtaining an answer. It must be clearly understood, however, that they by no means always provide a solution to the problem.

The number of internal conditions that claimants allege are derived from trauma is legion. Many may be logically dismissed by the fairly trustworthy analogy that if trauma to the abdomen can produce gall stones, for instance, a blow on the side of the neck should produce tonsillitis.

Perhaps the commonest conditions alleged to result from trauma are the two major personality states referred to previously, namely, neurosis and hysteria. From a strictly medical standpoint I

feel there might be occasional minimal evidence for considering a post-traumatic neurosis to be compensable in part but from the practical standpoint I believe no liability should be held. The difficulty of distinguishing between a true neurosis and a lie is frequently insuperable and besides, neurosis was to be held compensable generally all our casualty companies would probably be bankrupt within a few months. As for hysteria this is generally regarded, rightly I think, as non-compensable pre-existing state.

It should be mentioned that many people are prepared to disagree with the above statements.

2. We come now to the second alleged role of trauma in its aggravating capacity. In order to accept this theorem in any given instance, I think the following postulates should obtain, namely,

(a) The trauma must be of specific location and of such intensity that it could actually cause **de novo**, in some degree, the condition that is alleged to have been aggravated,

(b) Symptoms and signs of aggravation should develop **immediately** following the trauma,

(c) Objective signs of aggravation should be evident,

(d) The condition alleged to have been aggravated must be one capable of undergoing aggravation.

The following are some of the conditions most commonly alleged to have been aggravated by trauma, namely, arthritis, hypertension, heart disease, diseases of the nervous system. Let us test the aggravation of ordinary osteo-arthritis of the spine by an alleged trauma.

(a) The trauma must be directed to the spine either locally or by the anatomical transmission of forces,

(b) It must be so severe that a sprain or partial fracture is produced immediately, not the next day,

(c) There should be immediate incapacity, manifest by limitation of movements, muscular rigidity, local tenderness,

(d) A joint completely ankylosed by bone bridging cannot be aggravated except by a gross fracture.

In my experience the alleged trauma is usually too trivial to aggravate arthritis. In many instances the aggravation is alleged to occur in a joint that could not have been injured at the time of the accident.

When it comes to the traumatic aggravation of diseases of the nervous system, we are on much uncertain ground. In the first place, many of these diseases have a natural tendency to progression or even to spontaneous aggravation. Those who profess expert knowledge of these conditions seldom if ever have experience in dealing with traumatic conditions but yet the neurologists seem prone to agree that trauma does aggravate



disseminated sclerosis, Parkinson's disease, chorea and syphilis. They even go so far as to suggest that trauma may **cause** herpes zoster and syringomyelia. With respect I feel that the matter is not proven.

So much for the problem of aggravation.

3. Trauma may be named as a precipitating factor in certain diseases. In some instances this role may be readily accepted, in others its significance is not clear. The obvious group include such conditions as,

- fracture at the site of a pre-existing bone
- tumor or degenerative process,
- acute osteomyelitis in childhood,
- inguinal hernia.

Some of the infective diseases such as pulmonary tuberculosis have been held to be compensable as the result of trauma by virtue of the theory of the *locus minoris resistentiae*. Whatever the validity of this concept, I feel it has and will be overworked in an effort to establish liability where fortuity more likely obtained.

We have recently experienced a polio epidemic and you may recall the warnings that were given regarding trauma as a possible precipitating factor. I cannot imagine any court rendering a verdict that would reimburse a polio victim on the grounds that he acquired his disease through injury.

4. Trauma has been alleged to prolong the convalescence of a diseased condition present at the time of the injury. I have never met an instance where I felt trauma was so responsible. This role of course does not include aggravation of the condition previously present.

This has been a brief outline of one man's views on a subject which is ill-defined, unstereotyped and beset with pitfalls. But it is also a subject which is in process of evolution. The extraordinary increase in the incidence of trauma in our way of life is opening up new problems in the medico-legal field. These will inevitably require intensive study and one can only hope that as the years go by our knowledge of the trauma-disease relationship will progress towards clarification.

In closing I would like to offer a few suggestions that I feel may be of value in aiding the

medical examiner to come to concrete conclusions when assessing these problems.

Firstly, I feel much may be gained by insisting on two or more physical examinations, preferably carried out at intervals. It is curious that custom has come to accept a single examination as adequate. The most meticulous first examination is seldom a perfect one and during the subsequent pondering of the problem, one frequently recalls possible queries that have been missed. The public, however, would strongly resent the inconvenience of a repeat exposure.

Secondly: I would strongly recommend the adoption of a system of detective agency spying, to be invoked only when there is obvious doubt concerning a patient's disability. Many of you may be shocked at the proposal of such un-cricket like behaviour. However, Workmen's Compensation Boards and insurance companies have for years employed similar methods to the advantage of not only themselves but also of their principals.

Thirdly, where high stakes are involved and where skulduggery is suspected, it may pay the examiners to search for evidence of pre-existing disease in the files of the medical record rooms of hospitals and the film libraries of X-ray clinics. The routine enquiry as to the married woman examinee's maiden name naturally aids in such a search. I have known it to pay dividends in more than one instance.

Fourthly, I feel that the procedure sometimes adopted by counsel for the plaintiff, of refusing to permit the posing of questions by the medical examiner is not only a ridiculously planned obstacle but on the whole is detrimental to the interests of the patient. It seems to me to be a restriction which tends to reveal the bad points and conceal the good points about a claimant's injury. The ordinary thorough physical examination occasionally discloses concurrent but unsuspected disease—sometimes of grave significance, though of no relation to the accident. I have had the experience of finding suspicious signs of co-incidental cancer in patients with whom I have been unable to communicate. But the clandestinely whispered word of warning to the patient has been haughtily ignored.

## Geriatrics

### The Care of the Elderly in the Mental Hospital

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#### Introduction

The elderly population of the average mental hospital is heterogeneous, consisting of psychotics who have grown old in the institution together with patients who have developed mental reactions in old age. But whatever the psychiatric label, eventually a considerable number of these aged patients reach the infirmary wards with diagnosis of "senile frailty," "cardiovascular degeneration" and the like. Many are sent there because the nursing staff on other wards are afraid they will fall from totteriness, or because they irritate younger psychotics by hunting amongst their belongings, or quarrelling with them, and so become liable to injury. The infirmary wards eventually become overcrowded with old people who demand toilet attention rather than skilled nursing, who do not get on with younger patients, and who block beds which may be needed for acutely ill cases. In the mass their care is so exacting that nurses are reluctant to serve on such a ward for any length of time.

The mental hospital which is not faced with this situation must be exceptional. Moreover, the pressure of elderly admissions on the mental hospital is likely to increase even if society should provide alternative accommodation for the milder cases. A small number of mental hospitals are meeting the problem by forming specialized psycho-geriatric units within themselves, and the observations outlined below were made during the formation of one of these.

#### Organization

Separation of the elderly into a self-contained unit is of advantage both therapeutically and administratively; therapeutically because the unit can be made to provide an environment easily understood by the patient as well as affording opportunity for social and recreational therapy; administratively because it leads to the most efficient employment of nursing staff.

In dealing with the elderly psychotic the points to be remembered are:

1. While it is difficult and sometimes impossible accurately to estimate his physical status, he is generally capable of far more exertion than one thinks.

2. Unless he is acutely ill, mentally or physically, he does not need skilled nursing though he may need the help of someone with understanding and a little training.

3. Lack of physical and mental activity, in its most pernicious form by restraint or excessive confinement to bed is the surest way to get a troublesome patient. In the case of bed rest the degree of the apparent organic reaction may even be increased by cerebral oedema<sup>1</sup>.

Accurate classification of the patients by behaviour is of prime importance for the best use of the nursing staff. In the ordinary geriatric unit classification is by physical disability, long stay patients being divided into ambulant and frail ambulant. In a psycho-geriatric unit the classification must also include reference to the psychiatric disability and the following is suggested:

Class 1—Needing help with toilet, dressing habits, etc.

Class 2—Able to care for the person (a) Ambulant, (b) Frail ambulant.

Class 3—Needing constant observation for mental reasons.

Class 1 will be found to include all the very demented with a small number of physically crippled patients who have some mental alertness. It therefore includes the habitually incontinent, very confused and deteriorated patients. Practical experience showed that very few patients with mainly physical disability which might bring them into this class could not be included in class 2(b). Indeed, only about 5 to 10% of Class 1 were unable to get around without assistance and were too demented to use a cane or other walking aid.

Class 2 (a) patients require little nursing; Class 2 (b) do not require full nursing care though some patients may need ambulant forms of medical treatment. The majority of these will probably have cardiovascular changes as the main cause of their frailty; but in mental hospital geriatrics only the actually failing heart need call for strict limitation of activity, since the patient is not required to perform any great exertion in any case.

Class 3 is small, and is made up of new admissions under observation or receiving physical treatments. The number of psychotics who have grown old in the hospital and remain very troublesome is likely to be so small as to be negligible.

#### Accommodation

In the wards designed for classes 1 and 2 certain simple internal measures are desirable. The route into the bathrooms and toilets should have handrails along the walls so that frail and tottery patients may help themselves to get there. The floors should be non-slippery and without even slight projections. The great bogey of mental hospital infirm wards is falls with consequent fractures. Amongst the elderly living at home Sheldon<sup>2</sup> points out that 36.2% are liable to fall.

which may occur during an attack of vertigo, or be associated with trivial departures from the level—for the feet are not lifted so high as when the patient was younger and the power of regaining balance is less—or to sudden attacks reminiscent of cataplexy in which the legs give way.

The lighting must be good, as old people have difficulty seeing in the dark. Further, where stair cases are necessary they should have a double handrail so that patients may use both hands. In going upstairs accidents are likely to happen from tripping, in coming down from fear of falling. The security given by the double handrail is therefore well worth the trouble of its installation. Even frail patients, given this protection, are able to climb the stairs safely in their own time.

An observation and admission ward should be provided for Class 3. This ward may also take the acute sick from the rest of the unit. In our experience an average of 10% of the unit patients required accommodation for acute illness, though few of them were nursed in bed for more than a day or two.

### Equipment

Certain furniture and equipment, in addition to that usually present in the average hospital are desirable. For those cases who cannot get around and yet cannot use an ordinary straight-backed chair, being liable to fall from it, a hammock chair is very useful. These chairs should have a strong frame the seat and back being in one piece and suspended in the frame as in a deck-chair. Those actually used in our unit had the hammock made of canvas in the first place, later replaced by sprung upholstery covered in a waterproof material. The slight sag of the hammock makes it rather difficult for a restless patient to fall out of the chair. Moreover, with pillows and blankets the chairs can be used for early nursing of convalescents from acute physical illness or even for the nursing of acute illness in preference to a bed. With their use the bed sore and hypostatic pneumonia become non-existent.

In bathing class 1 and 2(b) patients a special type of bathtub is to be preferred. It should be of the Sitz type—short but deep, with a seat fixed or built on to the rear wall so that the patient can adopt a normal sitting position instead of reclining. For nursing convenience a low staging may be built around it if the tub itself cannot be partially sunk in the floor.

The bed-pan should seldom be used, for the elderly patient, especially if deteriorated, cannot manage it. A tubular steel wheel chair fitted with a toilet seat, which can be wheeled to the toilet and slid over the pan with the patient already in position is preferable. Where the patient cannot be taken to the toilet in this manner a bed-pan may be fixed beneath the opening to form a commode for bed-side use.

### Incontinence

Cosin<sup>1</sup> has pointed out the evils of bed rest for long periods in provoking cerebral oedema and incontinence, and other geriatricians agree on the potency of inactivity to cause both urinary and faecal incontinence<sup>4,5</sup>.

With the best of care, however, incontinence among class 1 patients is likely to be high, in the author's experience up to 30%. In view of this and the laborious nature of the work, it is probably desirable while retaining the supervisor to change the other ward staff at frequent intervals.

But it is a mistake to think that even demented patients are totally incapable of learning. In an experiment involving psychometric testing of demented patients before and after an interval, an improved response to the second test in the form of a more alert, relaxed and friendly attitude was found, even though some of the patients had no recollection at all of the first<sup>6</sup>. This has also been found in certain experiments at Brandon<sup>7</sup>.

Given that some learning or the recapturing of previously well-established habits is possible, incontinence may be vigorously tackled in the hope of getting a dry patient at least during the day. A main duty of the nurse is thus taking the patient to the toilet at frequent and regular intervals. A regular weekly or bi-weekly enema and the avoidance of mineral oil laxatives will usually clear up the spurious incontinence of faecal leakage. More often than it is realized, incontinence is due to laziness, apathy, or the inability of the patient to make his needs understood.

### NURSING AND TREATMENT

Class 1 patients require the most staff, the main employment of which is in getting up and putting to bed the mentally helpless. The major call on the staff is thus in the morning and evening, and staff saving can be effected by using personnel from other wards to assist at these times. In the author's opinion the staff should minimally consist of a supervisor, with a partially trained aide to every twelve patients, but naturally conditions will vary, and further experience will be necessary to find the optimum economic figure.

In the author's experience the main cause of physical disability in the elderly mental hospital patient is cardiovascular changes, with a few cases of anaemia, old hemiplegias, cataracts, deafness, and crippling from old fractures. Thus physical medicine in the form of remedial exercises, massage, and so on has only a limited application in the mental hospital compared to the ordinary geriatric unit where it plays a large part in rehabilitation.

In dealing with the non-demented down to the moderately demented but non-deteriorated patient, certain principles should be kept in mind:

1. The surroundings should be arranged so that they are not too much out of the ordinary



for him. Wards should be arranged less like a hospital and more like a home, with a reasonable number of comfortable chairs and other furniture.

2. The concept of fluid and crystallized ability described by Cattell<sup>8</sup> is well known. One may expect even a demented patient to preserve good habits both personal and of behaviour for some time after the intellectual faculties show an obvious decline. The patients should keep their wards clean, assist in making their beds, and so on, as far as possible. This is desirable even in the unlikely event of ample staff being available, since it helps the patient to feel of use.

3. All activities should be at a level familiar to, and therefore understood by the patient. Organized social activities designed for the elderly form probably the most effective single form of therapy in a psycho-geriatric unit. Regular gatherings of the old men and women should be arranged with the provision of card games, checkers, and so on, together with a few comforts in the way of refreshments and tobacco. The patients should be encouraged to provide their own entertainment, such as community singing. In actually starting such an arrangement it was found necessary to overcome apathy and actually to insist on reluctant patients attending; but the old folk soon came to look on the "party" as the high-spot of the week. An effort was made to suit the entertainment to their remote memories, and phonograph records of the songs of twenty years or more ago were obtained. It was singularly gratifying to see the response from patients normally sunk in apathy and thought too deteriorated to be helped.

4. Occupational therapy should be encouraged. The provision of suitable tasks will often require considerable thought. But even deteriorated patients may help in picking rags to pieces, or to knit cleaning cloths from string on large needles, while occasionally one will surprisingly produce a piece of fine work.

5. Exercise, in the form of outdoor walks, games of a gentle kind, and even dancing, is as essential for the old as the young.

6. Continuation of the family bonds, by encouraging relatives to visit and write frequently is of prime importance, not only in reassuring the patient he is not forgotten and helping to prevent apathy or depression, but, in keeping open a channel for the patient's eventual discharge.

The greatest single factor in running such a unit successfully is, and will remain, the enthusiasm of the medical and nursing staff. The latter especially, must have a genuine sympathy for their patients and a willingness to try out any measure to help them, however laborious.

Discharges from such a unit may not be many, as there are few facilities outside the hospital for proper care. This points to the need for more old people's homes with improved liaison between

them and the hospital. The staff of these homes could with advantage spend some period of their training in the unit. A recent report<sup>9</sup> suggests that a planned and energetic treatment approach in such a unit may actually raise the discharge rate considerably.

Even if discharges are not achieved, the unit serves a useful purpose in improving the mental and physical wellbeing of the patients and in considerably decreasing the nursing burden.

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### Must Alcoholics Become Abstainers?

The concept that the alcoholic is a sick man implies that the aim of medical treatment is to make him a well man. The belief that the man newly made well should then be able to drink like any healthy person is firmly held by many alcoholics. E. A. Strecker and F. T. Chambers (University of Pennsylvania) have remarked on the strength of the alcoholic patient's desire to become "normal" and, therefore, a "normal drinker" like his friends. It is this which makes it hard for him to accept the verdict that he can never drink at all.

Among alcoholics, C. Clapp was most emphatic in defying the claim that alcoholics must become abstainers. He described himself as the example of a thorough alcoholic who had become a moderate social drinker. Psychiatrists have admitted that in theory an alcoholic who has received adequate therapy should be able to drink moderately. But they have pointed to the hard reality that alcoholics who try to become abstainers often succeed while those who try to become moderate drinkers almost always fail. Many explanations of this fact have been suggested.

It is Alcoholics Anonymous, the largest group of problem drinkers who have found a workable solution for their personal drinking problems, who insist with strongest emphasis that an alcoholic can never drink moderately. The typical A.A. member who is "on the programme" is firmly convinced that he is "only one drink away from a drunk." In the ranks of A.A. the teaching is common that a single drink will start an alcoholic on a spree, though it is well known that many

confirmed alcoholics do not inevitably launch on a bender every time they try a drink. The distinction has been made that the alcoholic can never be sure that any one drink won't start him on a spree, and thus his only safety lies in refraining from the first drink—that is, in abstinence.

The proponents of two forms of medical treatment of alcoholism in recent years, on the contrary, have declared for moderate drinking rather than abstinence as the proper goal of therapy in alcoholism. R. J. Williams (University of Texas) considers alcoholism to be caused by individual, inborn want of essential nutrients such as vitamins. By supplying the alcoholic with enough of the nutrients he lacks, or which he needs in exceptional amounts, his perverted need for alcohol would be abolished, according to this theory. He should then be able to drink moderately without danger of going into excess. J. J. Smith (New York) holds that alcoholism is caused by an endocrine gland disorder and that proper treatment consists in the correction of this defect, as by injections of hormonal medications. According to Smith, such treatment should actually cure the alcoholic of his need to drink to excess and enable him to imbibe moderately.

More recently O. Martensen-Larsen (Denmark) has discussed a type of problem drinker who, in his view, should not be threatened with the alternative of abstinence or catastrophe. Agreeing that most alcoholics today must be treated with the objective of making them abstainers, he points to "an increasing number of patients still in a very early phase of their alcoholic career" who are now coming to clinics for advice. In order not to "frighten them away by demanding strict abstinence," he suggests that it would be worth while to try to help them modify their drinking pattern so that they might become controlled drinkers before they become "true alcoholics."

In spite of the theories of Williams and Smith and the occasional report of an individual alcoholic who has become a moderate drinker, the consensus among therapists is that, in the light of present knowledge, the establishment of a pattern of abstinence is the only practical goal in the treatment of alcoholism. Evidence that any treatment has made it possible for a substantial number of alcoholics to revert to controlled drinking for any length of time is lacking. On the contrary, the literature is replete with reports of alcoholics attempting to drink moderately and "slipping," as a result, sooner or later. Even Clapp, after years of controlled drinking slipped back into alcoholism and thereafter retreated into the safety of abstinence. And Martensen-Larsen's suggestion makes a clear-cut distinction between confirmed alcoholics, who must become abstainers, and a group of beginning excessive drinkers who may not be and may never become true alcoholics.

The consensus has been summed up in a review of contemporary treatments by G. Lolli (Yale University) as follows: All successful present-day approaches to the alcoholic "rest on two almost universally recognized assumptions: (1) Therapy should aim at total and permanent abstinence because the addict cannot shift from an uncontrolled to a controlled pattern of drinking. The occasional reported exception to this rule does not challenge its general validity. (2) The alcohol addict can remain abstinent only as the outcome of favorable readjustments in his personality."

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## Victorian Order of Nurses

### Intangibles

#### What is Nursing Care?

This question might command a variety of answers, depending upon the person to whom the question is directed. The recipient or the patient, is one to judge of its quality, sometimes justifiably harsh. The doctor is also concerned. The nurse who gives the care and in so doing gains satisfaction of her need to contribute should be the most critical judge. She sincerely hopes that the Sairey Gamps have been thrown out with the bath water. In order to analyze the quality of her nursing care she needs certain standards, an ideal for use in comparison.

It is the function of every agency giving nursing care to the public to keep this ideal constantly before all members of its staff.

#### How Does an Agency See That Its Patients Receive Good Nursing Care?

The quality of nursing care given depends to a very great degree upon the quality of the person giving it. In employing new staff members every agency tries to pick young women of highest personal qualifications—with maturity, interest, imagination, and acceptance and understanding of people.

Nursing is an art as well as a profession—that is it must have in it the quality of creativeness. This quality of creative imagination is necessary in all professions dealing with people, and is especially important in nursing the sick.

A nurse's training is based upon strict adherence to orders, since these orders come from

the person responsible for the patient's recovery and well-being. Because she is in a position to spend time with the patient, the nurse should function as an additional eye and ear for the doctor. This requires tact and powers of observation and discrimination. If in addition to these qualities the nurse has creative imagination she will be aware of the doctor's goals for his patient, and the patient's aims for himself.

Let us take an example from one of our own visiting nursing histories. In January Mr. W., a well known Winnipeg citizen, had a stroke. His left leg was very painful and weak, his arm paralyzed. Our first contact with the patient was when the family doctor called our office asking us to visit the home to give nursing care. He told us he did not believe the hemorrhage to be extensive, that he felt his patient had a chance for almost complete recovery. In outlining the simple exercises that he wanted the nurse to teach the patient and family he warned her that the patient had become completely dependent and resigned to invalidism. He asked that a lot of

encouragement be given along with the nursing care. In consequence as the patient, the family and the nurse worked along together, the nurse was careful to note and praise any slight signs of improvement, and to credit this to the patient and his family. As this story is being recorded Mr. W. is graduating from a crutch to a cane, and is busy every day giving instructions to his office staff by telephone.

We know that left to himself a patient is often unable to formulate realistic goals; he may feel great disappointment in the future because he aimed too high, or conversely he may fail to achieve maximum recovery because of a lack of encouragement along the way. To provide this encouragement to the patient and his family is one of the functions of total nursing care. Above all else, our patients need the understanding, sympathy and steady reassurance that the nurse can give. Stripped of these intangibles, the practice of nursing loses its soul, and, nothing is left but the empty husk of technical skill.

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\*Plowright, T.R.: *The Use of Carob Flour (Arobon) in a Controlled Series of Infant Diarrhea*, J. Pediat. 39:16 (July) 1951.

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## Fugitive Pieces

J. C. Hossack, M.D., C.M. (Man.)

### IX. What I Would Have Said

Some time ago my friends of the Brandon District Society invited me to attend their February meeting. Among other things they wished me to enliven their after-dinner proceedings by a talk. A number of circumstances conspired to make it impossible for me to comply, not the least being that I could think of nothing worthy to say.

You see, I am under a great handicap. My Muse is quite the most untrustworthy of her Union. (I presume that by now the Union idea has spread to Olympus). She is what Burns would term "a canty jade." Sometimes she will appear with quite good ideas, will set me in my chair, spread paper before me, put a pen in my hand and then proceed to dictate while I endeavour to keep up with her. That is very nice. But there are other times when no amount of coaxing will bring her out of her pouts. Then I shrug my shoulders until she is in a more agreeable humour.

She was in one of those fits when Bill Sharman got in touch with me and it was only after the meeting was over, and I really had no need of her help, that she said "About this Brandon affair; let's get on with it now!" "But," I said, "The affair is over. You can't expect them to summon the clans to hear what they were prepared to hear a month ago." To which she replied "You can write it down and publish it in your precious Review which always seems to be starving for material."

And so it comes about that, instead of heading this "What I Said," I must caption it "What I Would Have Said."

First of all I would have had a word to say about Brandon. In my mind it is linked with the husband of the young, beautiful and vivacious sister of Henry VIII. Charles Brandon, Earl of Suffolk, was brought up in the court of the seventh Henry and being handsome in person, charming in manner and of great courage he early won the love of the Princess Mary and she won his.

But a princess' will is not her own, for she is subject to her birth and may not, as unvalued persons do, carve for herself. War with France had lately been concluded and it was deemed expedient to cement the new friendship by the marriage of Mary to the widowed Louis XII. Louis had not reached the stage of lean and slippered pantaloons but he was certainly past his prime.

The Princess Mary may not have heard the Oriental proverb that the two worst things for an old man are a young wife and a good cook; but

then, again, she may have heard it. In any case she in her own person supplied the young wife, and a good cook was not hard to find in France. The combination worked and in a matter of months Louis had gone to join his ancestors and Mary, rejoicing in her widow's weeds, returned to England.

Absence had made two hearts grow fonder and, as soon as it was decent, the lovers were united in the holy bonds. Charles had, for his valour at the Battle of the Spurs, been elevated to a dukedom and thereafter, as before, played an important role in history. Among his other exploits is one for which we Scots have little reason to like him—he led the English forces at the Battle of Fallodon.

What links Charles Brandon, Duke of Suffolk, to the City of Brandon I do not know but that would be a nice inquiry for some historically minded Brandonite to undertake. (Audience reaction—mild interest).

A second topic I would have dwelt upon would have been Bill Sharman. Bill, as you all know, is a person in whom eccentricity does not merely fringe upon, but merges with, genius. A biography, preferably an autobiography, punctuated by his fluent verse, would be widely popular.

Bill is not a money-minded person but when an insurance agent told him how very profitable insurance was to him (the agent), and Bill realized how profitless it was to the examiner, he (Bill) decided to spend a little time lapping up this gravy.

He did very well at it; so well, in fact, that he was moved to New York and given the tough nuts that the other agents had failed to crack. His techniques varied but one of them was to find out in circuitous ways when the Big Shot was most vulnerable. At the critical hour Bill would appear and hand his professional (medical) card to a secretary. Naturally a doctor would be seen if at all possible.

Once inside Bill would open his sphygmomanometer. Of course the "Big Shot" would say "What's that for?" or some like remark, whereupon Bill would say it was for taking blood pressure. "I represent the Everlasting Life Assurance Company. If your pressure is above a certain point I won't waste either your time or my own by talking insurance. Roll up your sleeve please."

Nine times out of ten curiosity led the victim to take the first step towards signing on the dotted line. An applicant isn't in a position to argue when a doctor tells him that normal today doesn't mean normal next week or next month. I can imagine Bill, in his missionary zeal for the welfare

of his company, urging that now was the appointed hour, now was the time for decision.

But Bill is by nature an honest man and he returned to practice. Even here, however, his ingenuity did not desert him. In the little town where he was on a municipal contract he would espy some one by whom he had not been consulted. Him he would approach saying "How long since you had your urine examined?" The man would reply "I've never had it examined." "Then how do you know you haven't got diabetes?" "I know I haven't got diabetes." "My friend, don't you remember the little poem: 'I don't know what a moron is, And I don't give a damn, Because I'm not a moron—By Gad! perhaps I am!'" Come on, brother. Let's have a look at your water."

Of course the man had his water, and his body also, examined. And now and again something was caught early that would have been hard to treat later. In addition to the above approach he had others including the blood-pressure one. All together this was a most useful service—preventive medicine without advertisement or ballyhoo. And also without any reward. His income being fixed he was merely adding to his labours, not to his income.

Bill's inborn optimism makes him an ideal morale-builder. This was put to use during his stay at the Mayo Clinic whither he had gone for the removal (successful, fortunately) of a malignant growth. One day his surgeon, impressed by his philosophical good spirits, told him of another patient, also a doctor, who was wallowing in the Slough of Despond and sunk in depression. Bill undertook to see him. He told the man that they had occupied the same operating table for the same operation at the hands of the same surgeon and on the same day. The Californian could not understand how anyone who had gone through what they had gone through could be so nonchalant, so satisfied that there was nothing to fear. But by the time he was ready for discharge, and thanks to Bill, the Californian also had found courage, hope and peace of mind. (Audience reaction—moderate interest and a glowing warmth towards Bill Sharman).

I come back to Brandon again. I have a picture in my mind as it was when I last saw it. I motored through on a pleasant evening. Perhaps my memory may play me false but I have a recollection of descending a road to the bridge. The town was wrapped in a violaceous, hyacinthine veil, and looked pretty and inviting and peaceful. I did not stay nor have I seen it since. But I know that there are in it three buildings which are sermons in stones. On the whole they are sad places where many tears have been shed. They are the hospital, the asylum and the gaol.

There was a time when a hospital was a place where people went to die. Written invisibly

above its entrance was "Abandon hope all ye who enter here"—or so it seemed to the old and fearful who looked upon hospitals with dread and distrust. Of course it was not true. Even then the braver and less discouraged entered it with "Nil desperandum" upon their lips.

I do not know how long the hospital has been in existence but if the walls of its rooms had tongues as well as ears what stories could they not tell! They would speak of doctors and nurses bent over bedsides where Death was wrestling with the doomed and would not be denied. There would be stories of the anxious moments of pneumonic crises; of hopeless struggles against virulent germs that took children and bent them backwards as one might draw a bow; of the sinking feeling of suddenly grave doctors who found in spots and spleen and heart-sounds the evidence that life's candle was guttering in its socket—and such a short candle it had proved to be.

Great have been the triumphs of medicine. But is it not humbling to think how much we, the acme of creation, owe to the lowest of created things? And surgery also has its victories. And how vastly has its field been changed by these same lowly particles that are not even creatures. Infections, once so mutilating and fatal now are crushed before they can be mischievous.

It is interesting to trace the literal rise of medicine. In the beginning, perhaps the only efforts made by the earliest of doctors were to rid the feet of thorns and to heal their cuts. Next attention settled upon the perineum which for centuries if not for millenia has continued to hold men's interest. Then the soft-walled abdomen invited exploration by curious men who had learned how to make knives. Next the encaged viscera of the thorax must be attacked till now surgeons can pass their fingers into the very heart itself and do such marvels as were undreamed of even a generation ago.

And now the skull no longer is a barrier. "The time has been That when the brains were out the man would die And there's an end; But now they rise again." They rise again, and often go to work and live long and useful lives.

The invisible warning "Abandon Hope" has long since disappeared from over the hospital door, and "Nil desperandum" has followed it. Now we know, that if we could but see it, it would read "Be glad, for here you will find health."

We now must cross the river to a building that might once have had its place in the City of Dreadful Night. In the Hospital one sees our triumphs over the ills of the flesh but here men labour in that intangible field—the mind. And here, too, there have been victories for we have learned how to minister to minds diseased, how to pluck from memories their rooted sorrows, how to raze out the written troubles of the brain. The door for which so long

we have lacked the key is being opened, the veil which for so long has blocked our vision is slowly thinning. The end is not yet but surely it is in sight. No longer do those who enter leave hope behind for the word is "Do not despair." (Audience reaction—moderate interest).

Grim though they are, asylums are not always devoid of healthy laughter. I have in mind the picture of a lunatic looking over the wall that fenced him in. It edged a river and below him on the bank was an angler. Evening had come and the day obviously had been one of continual rain. "How long have you been fishing?" asked the inmate. "Since sunrise" answered the fisherman. "Caught anything?" "No." "Come inside."

And I recall another incident where two mildly silly trusties were in conversation with a normal friend when the mutings of a passing bird fell upon the clothing of one of them. The other dashed off saying that he would bring some toilet paper. The foiled one turned to his friend and said "He's crazy. The bird will be miles away before he gets back with his toilet paper."

And another of the same sort. A chronic grumbler (sane this time) was complaining to his clergyman about how harshly the world was using him. Everything was going wrong in every way. The clergyman pointed out to him many things for which he could be grateful and urged him to lift his head to the heavens and give thanks for what he had. The grumbler looked upwards just in time to get the mutings of a bird into his eye. His prayer consisted of this single sentence: "You see, Lord, what I mean." (Audience reaction—definitely favourable).

"Abandon Hope," so long ago banished from the hospital, so recently inapplicable to the asylum, still clings to the gaol. Our interest, if any, in that place of confinement is a morbid one. "It is," we say, "a place where perverse men pay the price of their perversity." But is it not rather a place where perverted men are being punished for their perversions, and are not perversions, being mental phenomena, our professional concern?

They are our concern yet do they occupy us as they should? Few will deny that alcoholism is a disease and drug addictions also. We know that the addict, sooner or later, is driven into crime. Yet we make no concerted effort to avert this tragedy-in-making. Is it not pathetic to think how

the hapless victims of alcoholism, finding us turn from them as did the Levite, were driven to band together to comfort, support, encourage and mend themselves? How shameful it is to think that what we could have done, and should have done, the sick were forced to do for themselves. And we are content to leave the problem of drug addiction to the police.

If crime is a form of madness, as it seems to be, then as madness it must be treated. The little insanity of unimportant men is troublesome; and it is dangerous when it burgeons forth in crime. But in these perilous times the great insanity of demagogues and leaders of nations is infinitely dangerous. What would be now our fate had Hitler's scientists progressed as far as have our own?

The ills of the mind seemed to be beyond our control even when those of the body had become manageable. It seemed impossible that Reason, exiled and imprisoned, could hope again to sit upon her throne. But now we know she can. And when we look today upon our crime-infested world, the task of cleansing it appears quite hopeless. Yet is there a solitary ailment of body or of mind of which we say: "Here our efforts will be forever bested?" And if we can see victory in every other field, why should we be defeated here?

Perhaps the reason why crime flourishes is because neither Society nor ourselves have looked sufficiently at the medical aspects of the problem. Only those who understand the workings of the mind can change despair to hope and hope to fulfillment; can change the ugly facts of today into unpleasant memories. And who can do this if not ourselves? (Audience reaction—True, true, but boring).

The hospital, the asylum, the gaol—the place of conquest, the place of successful contending, the place yet untouched—three sermons in stones. He who hath ears to hear, let him hear.

"At this point" says my Muse "you had better stop. They're beginning to fidget. You should have a funny story to end with ("always leave them laughing when you say goodbye" you know) but for the life of me I can't think of one. Anyway it will be a relief just to have you stop. And don't fool yourself about the applause. It's not because of what you have said but because you have quit saying it!"



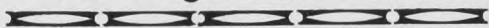


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### Midwinter's Daydream or Journey Through Medstutopia

S. Vaisrub, M.D., M.R.C.P. (Lond.), F.R.C.P. (Can.)  
F.A.C.P.

I landed in Undergradton, a suburb of Medstutopia, during the siesta hour. My guide and host, a young resident in Radiology, met me at the airport in his sparkling new Rolls-Royce. After the usual exchange of greetings and polite inquiries he led me to his car and drove me leisurely through the quiet streets of Undergradton along the beautiful Alcock's Canal, past the famous Boulevard Premedical into the main street of Medstutopia. The city, as everyone knows, is beautiful beyond description, and its main street located on the slope of a hill is unlike any other main street in the world in that it has no business establishments of any kind. The buildings, of white marble and yellow brick, are all bars, cafeterias, restaurants, theatres, and gambling houses. My host stopped at what appeared to be a sidewalk cafe on the summit of a hill, and after steering me gently to a table with a breath-taking view of the city he proceeded to study the menu. From the interior there came sounds of laughter, clinking glasses, and words of endearment to a pair of dice. It was then that I noticed that the pretty, young waitress who gracefully sidled up to our table wore a well-camouflaged skin-colored French bathing suit which would have been totally undetectable, were it not for a lovely floral pattern on some strategic areas. With a charming smile she took our order of chicken roasted in champagne, and then asked me for my autograph. Needless to say I was flattered and gladly complied with her request. My only regret was that I was unable to prolong my stay in Medstutopia so as to extend my activities beyond the line of duty.

My host, who noticed my interest, warmly commented upon the intellectual accomplishments of the young lady, who, apparently, was a second year Medical student and had been awarded a certificate of merit in Anatomy. She was also considered to be an expert in experimental Biology. Being a member of the "Earn As You Learn Club" she worked her way through college alternately as waitress and strip tease. I also learned that the place we were eating in was no ordinary sidewalk cafe but a students' canteen, where such modest fare as barbecued chicken, fried pheasant and roast duck could be purchased for a nominal price. Champagne was free, but the amount was limited to three bottles per person. This restriction, apparently, caused once a near riot among the patrons who regarded it as a violation of academic freedom.

Having, thus, satisfied my curiosity about my immediate surroundings, I turned my attention to the neighbouring tables and the passers-by. Practically all were young, gay, and debonair. The men wore a dazzling variety of colorful clothes, zebra coats and red trousers predominating. The women, for reasons of economy, I presume, wore but scant apparel reflecting the influence of the Fiji Islands rather than that of Paris. There was an air of youthful buoyancy about them. Some strollers would stop at frequent intervals at a sidewalk bar or a nearby fountain from which spouted a yellow, foamy liquid, to quench their thirst. Others, apparently of a more scholarly type, would gather around an outdoor bookstand to buy a book or magazine.

Curious about the reading habits of the Medstutopians I strolled over to the bookstand. The best sellers, seemingly, were mysteries by one-named Nicky Chillane with some bloodcurdling titles. One entitled "A Bite In the Night" was particularly popular. There were also some medical books which were in high demand. They were of small sizes and bore rather curious titles. One, named "Medicine In Six Easy Lessons" was selling fast. Another called "Short Cut to Medical Knowledge" was also currently popular. A quaint little volume titled "Medical Mnemonics" full of medical verse and other memory aids had been also attracting attention.

What attracted my attention, however, more than the books and journals was the appearance of the owner of the bookstand. Middle-aged with a balding-pate and a pasty face, several days removed from a shave, dressed in shabby ill-fitting clothes, he was the very antithesis of all the beauty, youth and color that surrounded him. As if reading my thoughts he explained to me, with his sad eyes averted, that he was a demoted professor. He also pointed to a few street cleaners clad in dirty overalls, and to a man, whom I judged by his clothes to be a chimney sweep, all of whom having escaped my unobservant eye, stating that they too were demoted or dismissed members of the Faculty. The puzzled and incredulous look on my face coupled with my assurance that I was a stranger in town totally ignorant of local customs led the man to further confidences. It appeared from his astounding story, a story subsequently confirmed by my host and guide, that the plight of the members of the teaching staff of the medical college in Medstutopia was well-nigh incredible. They were under constant surveillance by the student body, with the slightest faux pas, be it the least departure from the conventionally prescribed dress (dark grey single-breasted suit, blue shirt, black tie and black pointed shoes with grey

spats), or the smallest act of discourtesy to students resulting in a severe reprimand, demotion or dismissal. The latter, of course, meant either starvation or menial labor, as no other positions were open to these poor unfortunate outcasts whose sufferings apparently aroused no sympathy whatsoever.

Surveillance, however, was the least of their woes. They were plagued by examinations, a Sword of Damocles, that hung over their heads every spring. It appears, that in Medstutopia the tables were turned. Every spring the students examined the teaching staff. The examination was the event of the year, not unlike a bullfight in Spain, an event looked forward to with joyful anticipation by the students and dread and apprehension by the professors. The preparations for the event were elaborate. The student body would elect a Board of Examiners from their own members. Toughness of fibre, implacability, and cunning, with a dash of cruelty, were the qualities looked for in a successful examiner. The duly elected examiner would then take short courses in such subjects as: "vagueness and ambiguity," "traps for the unwary," "man-hunt," "the surprise attack," "the softening up," and "the knockout blow." Having completed the courses they would then set out to prepare the papers and oral examination.

At this point our conversation was interrupted by a customer who asked for a copy of the Chinsey report on "The Sexual Habits of the Medstutopian Adolescent," a book, apparently, on the best seller list. Having effected the sale my sad-eyed friend returned and reaching into his pocket with his trembling hand (for differential diagnosis of Tremor see Russell Brain Diseases of the Nervous System, page 350) he produced a few crumpled sheets of green paper and handed them to me. They were examination papers of the previous year. At first glance the questions looked harmless enough, differing but little from the ones I had to write during my multi-examinational career. It was only on re-reading them that I began to understand how some of the candidates were driven to suicide, while others ended up in a padded cell. The following is a transcript of the paper:

(1) Discuss high output failure in a patient with left ventricular failure complicated by peripheral circulatory failure in the light of the backward failure theory. (Failure to answer this question correctly spells failure in this test for this question is assessed at 30% of the paper.)

(2) Discuss K in health and disease. (75% of the class discussed potassium. To their dismay they found that what was wanted was vitamin K.)

(3) Describe Peroni's disease and its physical, chemical, physiological, psychological, and sociological aspect.

(4) Describe in detail (giving some good recipes) a low salt, low cholesterol, high fat, gluten free diet, which is rich in calcium but poor in phosphorus and potassium.

(5) Discuss Diaphoresis in health and disease. What is the physiological basis and mechanism of "Cold Sweat," "Sweating Blood," "Sweat, Blood and Tears?"

(6) Write a thousand word essay with appropriate quotations from the Bible, Shakespeare, and Osler on the following:

(a) Future of research.

(b) Medicine, what of tomorrow?

(c) Phenomenological versus Existential Concept of disease. (One of the candidates surprisingly passed by ignoring the question and quoting extensively from Nicky Chillane, thus worming his way into the heart of his examiner who happened to be a Chillane fan.)

(7) Explain the following quotation: "Mature humanistic, scientific procedures based on scientific observations and analysis of natural phenomena flexibly interpreted in the light of basic biologic philosophic postulates and integrated as far as possible with other disciplines and fields of human knowledge." (I was told that one of the successful candidates got away with it by summarizing the above quotation in one word designative of an animal of the bovine species.)

The oral examinations were, according to my kind informant, even more trying. They are held in a large auditorium amidst great fanfare and the sounding of trumpets. Students gather en masse and heckle the poor victims thus contributing to their confusion. The questions are tricky, and no amount of knowledge and preparation can insure one against failure.

As I was about to ask a few more questions I noticed that my host, who was sitting at the table sipping his Cointreau and exchanging pleasantries with the comely waitress, was eyeing me rather disapprovingly. I gathered that fraternizing with a demoted professor was frowned upon in Medstutopia. With a sigh of regret I left the bookstand and returned to the table. My host politely suggested that we continue our sight-seeing tour. After taking leave from our scholarly waitress (to whom, I presume, my host was engaged, for otherwise it would be difficult to explain certain liberties that he was taking with her without casting aspersions on their moral character), we proceeded to the car and drove off.

Within twenty minutes we were outside the city limits driving through the most picturesque country side that ever met my eye. Suddenly, I became aware that the horizon to the east became blurred and then to my utter amazement I saw a gigantic curtain stretching as high as I could see and as far to the right and the left as my eyes could reach. Within a few minutes we were right



at the monstrous partition. At close range it became obvious that the curtain was made of iron. My host took out of his pocket a reflex hammer and began to tap on the metallic curtain in what seemed to be the morse code. Instantly a peephole was opened and a hoarse voice asked for the password. "Vodka," said my host, and, as if by magic, a crack appeared in the curtain and here we were behind it in the heavily guarded Commedstutopia.

The guard was very polite. While scrutinizing our papers, which he held in his right hand, he deftly pocketed a thick wad of rubras (the value of the rubra being twenty-five cents at the official rate of exchange, but actually only half of that in purchasing power), which my host gave him by way of a bribe, with his left hand. As neat a case of the right incorruptible hand not knowing what the left venal hand was doing as I ever saw. Having expressed the satisfaction on both scores (documents and bribe) he assigned to us a guide and interpreter, a tight-lipped young man with a dead pan expression, who, as subsequently turned out, was an invaluable source of information for he was a member of the Commedstutopian Board of Examiners. The guide drove us around in a jeep through narrow cobblestone streets. It was late in the afternoon and there did not seem to be very many people about. The strollers, students of both sexes (it was at times difficult to tell the difference as both were wearing overalls and denims) looked happy enough, but in a stern sort of way. Even the couples who displayed some degree of alcoholic Ataxia (for differential diagnosis of Ataxia see Pavlov, page 239) and amorous behaviour had about them a look of grim determination. There were no open-air sidewalk cafes, but from behind closed doors and barred windows could be heard music and the sound of revelry.

As we turned the corner towards the Students' Canteen, we beheld a gang of weary, emaciated men clad in rags, bound to one another with iron chains, led by armed guards. Noticing my pained and shocked look our guard reassured me that there was no need to waste sympathy on these

wretches, as they were senior members of the teaching staff who failed in their examinations. He then proceeded to explain that failure in examinations is considered, in Commedstutopia, an act of sabotage and is punishable by severe prison sentences. Some of the culprits would be "persuaded" to write lengthy confessions. The prisoners even had a journal called "True Confessions," published by the members of the Faculty who fell into disgrace. Some minor offenders, who failed by dint of a small slip-up were re-installed after a brain washing session. The latter was done either by irrigation of the brain through burr holes in the skull or by hydrating the victim while withholding salt, thus causing intracellular cerebral edema. The major offenders were oblivionated (synonymous with liquidated). Some were compelled to stay awake while listening to dictaphone recordings of their own lectures (the most diabolical of all tortures!)

At this juncture I could not help expressing, before our guard, my disapproval of these cruel methods which compared unfavorably with the humane and gentle way of Medstutopia to the west of the iron curtain. Ignoring the warning look on the face of my host I then took out my camera and proceeded to photograph the sorry procession. This resulted in a surprising development. With a sudden twisting movement our guard snatched the camera from my hands, and accusing me of espionage drove me straight to the police station. The grim unsmiling face of the police sergeant at the desk sent shivers through my spine. The shivers seemed to concentrate particularly in my lower lumbar region. As if reading my mind the sergeant suddenly began to kick me with his boot in the same area, thus adding injury to insult. The pain shot down my left leg. I felt then that there would be no happy ending to this story . . .

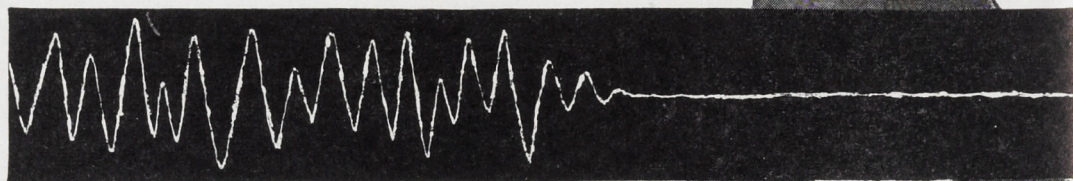
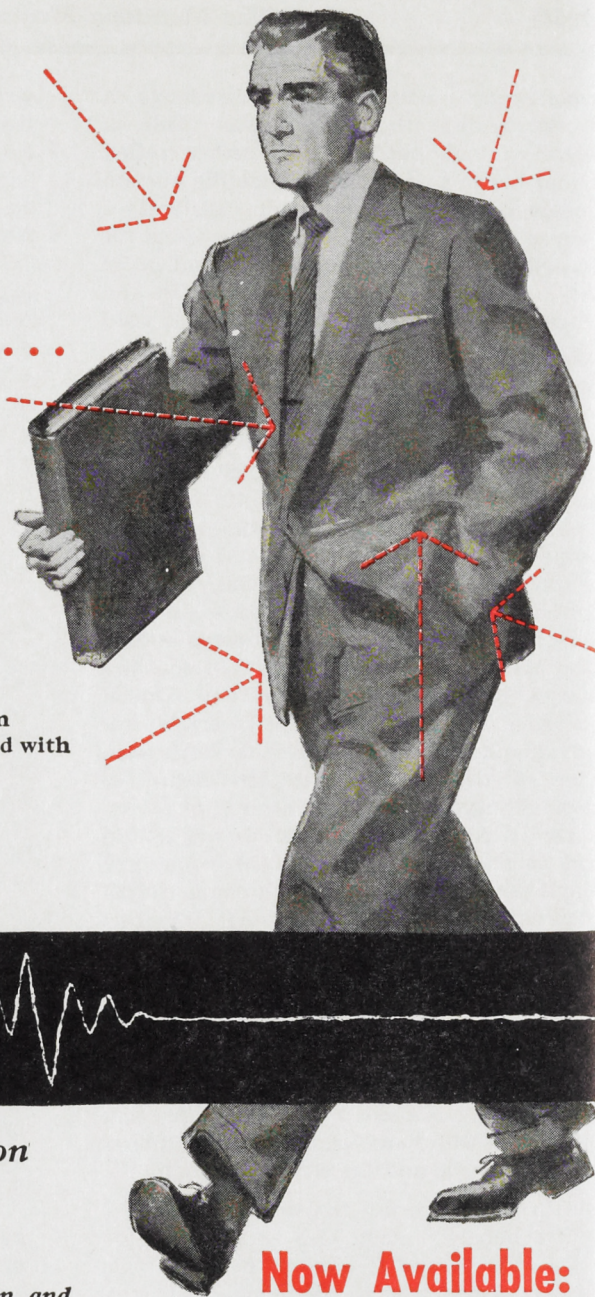
I was mistaken, however, for when I woke up and got up from the table my physiotherapist, with a face surprisingly like that of the police sergeant, smilingly reassured me that my back was more supple. And indeed it was. My Sciatica left me and I was able to walk again.

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## Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

### Looking Ahead

It may seem very early in the year to think of the event of the Autumn—the Convention. Yet time flies with such speed that October will be here almost before we know it. Moreover, during the summer months pens are not likely to be active. Therefore now is the time for everyone to ask him or herself whether or not he or she means to contribute and, if so, what.

In years past the tendency has been for contributions to trickle in very late in the season. Programme committees have found it difficult to arrange the programmes, papers were so slow in arriving, some, indeed, coming to them almost on the eve of the meeting.

By starting now authors can plan and complete their papers in a leisurely way and be able to respond quickly when the Programme Committee advertises for contributions.

It would, we believe, be appreciated by the members of the Association if the Programme Committee were to arrange for a larger than usual number of outside speakers. If the programme were made up chiefly of authorities from elsewhere in the Dominion and from abroad—even from Great Britain—the attraction of the meeting would be greatly strengthened.

Our geographical position is such that the usual attendance could easily be doubled. Prominent authorities, well advertised, could be counted on to make our Convention outstanding. As we have mentioned before, if Winnipeg can stage the largest Musical Festival and the largest Bonspiel, there is no reason why it should not be the scene of a very large and important medical meeting. But first of all we must have a sufficient number of distinguished speakers and we must give them wide advertisement, not only in our own and the adjacent provinces but in the neighbouring American States as well.

Another matter which is important is the date of the meeting. It used to be the practice for the Western Conventions to begin alternately in Manitoba and in British Columbia. For some years past we have always been the last of the four. October is not the best month for a convention here. The weather is cold and uncertain, and as a result golf and other outdoor activities cannot be included in the social programme. We believe that the Association should ask for a reversion to the old plan or a reversal of the present one in which case ours would be the first. To that there could be little objection because the light hand which winter lays upon British Columbia would not even have begun to descend.

Our latest independent convention was in 1952.

For the first time it occupied four days and never before had the attendance been so large. In part this was due to the number and calibre of the guest speakers. And this was done with a minimum of publicity.

The cost need scarcely be considered. The larger the attendance the larger the number of exhibitors. Incidentally, and altogether because of the skillful management of Mr. Whitley, ours has, among the exhibitors, the reputation of being the best organized of all the conventions not excepting the national one. The assurance of a large attendance would be followed by an increased number of exhibitors and increased revenue.

But even if that were not enough few would object to a registration fee if it meant that they would have the chance to hear six or eight or more outstanding speakers. And then, why not arrange for the Tisdall Lecturer come before a large convention audience rather than before the small society ones these speakers usually address? And it is a long time since there has been a Gordon Bell Lecture. The one who delivers that public address could also give at least one professional lecture.

We believe that if the four days were chiefly, almost exclusively, given over to distinguished visitors our convention would quickly gain a national reputation and significance. There is no reason why it should not.



### Letter to the Editor

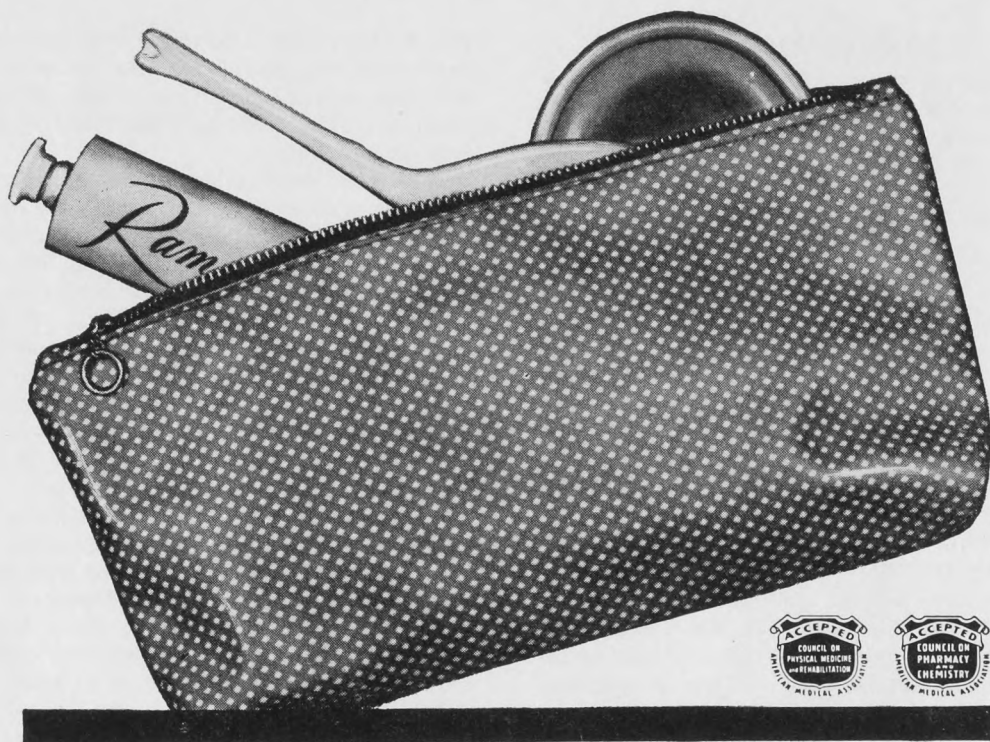
Editor,  
Manitoba Medical Review,  
Dear Sir:

I should be grateful if you would allow me space to correct an error which appeared in an article in your February issue on "Recent Experience with Tumors in Children." In case 1 Dr. Popham is quoted as having stated that in the treatment of one case the surgeons were "turned aside from their original plan for immediate surgery" by a suggestion that radiotherapy should be given.

I should like to point out that there was no "plan for immediate surgery." On the contrary, the surgeon in charge of the case had, after consideration, decided that the case was quite inoperable. He then discussed the case with me. I offered to give radiotherapy on the ground that if the tumor were radio-sensitive it would undoubtedly shrink enough to permit the surgeon to reconsider his decision. As it turned out, the tumor was not radiosensitive and treatment was stopped.

Yours sincerely, James E. Bennett, M.B., Ch.B.





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## Manitoba's Medical Men

### VI. Public Relations

Public relations begin in the case room. The first thing the doctor does with the new patient is to spank him until he cries. This observation made by a doctor from the prairies, does not give a true picture of our relations with the public. The lay person can understand this example, but there are many other examples of public relations which he finds difficulty in understanding. Some complaints against the doctor are valid and would be eliminated if each doctor practised good medicine and individual doctor-patient public relations.

In the province of Manitoba our relations with the public and the press and the government are very good. There appears to be a sincere desire on the part of all groups concerned to do as much for the patient as is possible with our limited resources. The increase in the cost of medical care is due in a large measure to the increase in hospital costs and to the use of newer forms of therapy. The effect of this, a fact usually overlooked, is to reduce the number of days a patient has to stay in hospital by more than 50%. This reduces the total hospital cost to the patient. The medical fee has not gone up a great deal in the last few years, but people still think about the expense of sickness as an outlay of money to the doctor, although most of the cost has been for hospital care.

There are many facets of public relations that cannot be dealt with on a provincial level and for that reason have to be dealt with on a national level. The Canadian Medical Association has a committee on public relations under the Chairmanship of W. G. Bigelow. Recognizing the fact that public relations programs have to be initiated to a large extent at the provincial level, a conference was held in Toronto this month at which the chairmen of public relations from all the provinces were present. In this way the nucleus committee of the C.M.A. was able to get a coast to coast review of the activities of each province in the field of public relations.

In his opening remarks to the conference, Dr. Arthur D. Kelly indicated that there were four areas of misunderstanding between the patient and the doctor. These were:

1. The doctor was disinterested in the individual problems of the patient.
2. The cost of medical care was too high.
3. The profession was too materialistic.
4. The profession functioned as a "closed shop."

#### The Press

The Canadian Medical Association has very friendly relations with the newspapers across Canada. It was pointed out that the newspapers across Canada did an excellent job of reporting

the annual meeting held in Winnipeg last year. This was made possible by a public relations man employed by the association and assisted by our own men in the province and the co-operation of the speakers. The press room was an important factor. The newspapers are very anxious to get news on matters of health because everybody is interested in health. The medical news given to the newspapers has to be accurate. The reporters, with very few exceptions, are anxious to give an accurate report of medical happenings, but it must be made available for publication promptly, or it loses its value. It was pointed out at the meeting that the code of ethics states that "a physician should insist, wherever possible, on seeing a proof of what is to be printed under his name or on his authority," but this is not always possible so that a certain amount of trust between doctor and reporter has to be established. Checking the copy has to be sacrificed in many cases to the need of speed.

#### Radio

Radio programs arranged by the Provincial associations are becoming increasingly popular. British Columbia, Manitoba, Ontario, Quebec and New Brunswick have a series of programs going now. In British Columbia the doctors prepare the programs, but in some other provinces they are already prepared and authenticated. The code of ethics was referred to again and read as follows:

"It is legitimate and even desirable that topics relating both to medical science and policy and to public health and welfare should be discussed by physicians who can speak with authority on the question at issue. In any medium of discussion, but especially in radio broadcasting because of its vast range, it is essential that the physician who takes part should avoid methods which tend to his personal professional advantage. Not only should he personally observe this rule, but he should take care that the announcer in introducing him makes no laudatory comments and no unnecessary display of the physician's medical qualifications and appointments."

#### Forums

These have been underway in British Columbia for some time. Speakers were selected who had good diction and were able to use simple language. One whole hour was allowed for the script and half an hour for questions. The forums have been well attended and well received by the public. They propose to have a forum at the annual C.M.A. convention in June of this year as part of the program.

Forums are also underway in Saskatchewan and have just been initiated in Ontario. The topic chosen for the latter was "Poliomyelitis."

#### Television

Arrangements are being made to use this medium on a national level. Here especially, great

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Vitamin B <sub>1</sub> .....	1 mg.
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Vitamin B <sub>12</sub> crystalline .....	0.5 mcg.
Vitamin A (acetate) .....	800 I.U.
Vitamin D .....	500 I.U.
Vitamin C .....	25 mg.
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## Your Eyes

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care in the preparation and presentation of material on medical topics was considered to be essential. In the United States the March of Medicine television programs are rated very highly both with the public and the profession.

### Mediation Committees

These have done a great deal in the way of public relations in cases where there was alleged overcharging. Attempts were made to have these problems settled on a local level. In a few cases top level decisions had to be made.

### National Health Insurance

Dr. Routley considered it important to bring once again to the attention of the profession, that the C.M.A. does not oppose National Health Insurance. In the statement of policy of 1949 article 6 reads as follows:

"The Canadian Medical Association, having approved the adoption of the principle of health insurance, and having seen demonstrated the practical application of this principle in the establishment of voluntary prepaid medical care plans, now proposes

(a) The establishment and/or extension of these plans to cover Canada.

(b) The right of every Canadian citizen to be insured under these plans.

(c) The provision by the State of the Health Insurance premium, in whole or in part, for those persons who are adjudged to be unable to provide these premiums for themselves."

The whole conference on public relations was carried out in a very efficient manner; the credit for this must go to the nucleus committee of the Canadian Medical Association.

L. A. Sigurdson, M.D.

### Medical Library Association

The Medical Library Association will hold its Fifty-third Annual Meeting June 15-18, 1954, in Washington, D.C. The headquarters will be at the Hotel Statler, and the official host the Armed Forces Medical Library.

The program will include a discussion on medical research by embassy attaches, tours of the National Institutes of Health, the National Naval Medical Centre, and of the Armed Forces Medical Library. Delegates to the meeting will hear addresses by Dr. Detlev Bonk, President of the Rockefeller Institute of Medical Research; Lt.-Col. Frank B. Rogers, Director of the Armed Forces Medical Library; Mr. Verner Clapp, the Acting Librarian of Congress, and Dr. Raymond Zwemmer, Chief of the Library of Congress' Science Division.

Further information can be obtained from Lt.-Col. Frank B. Rogers, Armed Forces Medical Library, 7th Street and Independence Avenue S.W., Washington 25, D.C.



## Association Page

Reported by M. T. Macfarland, M.D.

### North of 53 District Medical Society

The Annual Meeting of the Society was held at Flin Flon on Wednesday and Thursday, February 10th and 11th.

Following lunch at the Staff House, visitors were shown over the property of the Hudson Bay Mining and Smelting Company Limited by Mr. M. A. Roche, Assistant to the General Manager.

Refreshments were served at the home of Doctor and Mrs. H. L. McNicol, and a delicious dinner at the home of Doctor and Mrs. Percy Johnson was enjoyed by all.

Present at the Business and Scientific Sessions which were held at the Conference Room of the Staff House, were the following:

**Flin Flon:** Drs. H. L. McNicol, President; P. Johnson, Secretary; A. A. Campbell, J. A. Killoh, C. A. Milanese, E. L. Redpath, N. S. Stephansson, G. N. Willson.

**The Pas:** Drs. C. S. Crawford, J. Leicester.

**Winnipeg:** Drs. L. G. Bell, D. Parkinson, W. F. Tisdale, T. D. Wheeler, M. T. Macfarland.

Doctor L. G. Bell, Dean, Faculty of Medicine, University of Manitoba, spoke on "Modern Trends

in Medical Education," and Doctor D. Parkinson's subject was "The Treatment of Acute Head Injuries." Both papers were discussed at some length.

At the Business Session the following officers were selected for the year 1954-55:

President ..... Dr. C. S. Crawford, The Pas  
Secretary ..... Dr. J. Leicester, The Pas  
Representative to

Executive M.M.A. .... Dr. P. Johnson, Flin Flon

Announcement was made of the Sectional Meeting, American College of Surgeons, to be held at Montreal in March.

Dr. W. F. Tisdale, President, brought greetings from the Manitoba Medical Association and Dr. M. T. Macfarland, Executive Secretary, discussed some trends in Public Relations.

Following the meeting members were guests at the home of Doctor and Mrs. McNicol for an enjoyable lunch.

On Thursday, February 11th, members visited the General Hospital and took part in a Clinical Discussion of cases presented by Doctors Campbell, Killoh and McNicol.

A dainty luncheon was provided at the General Hospital through the courtesy of the Sister Superior and staff. A vote of thanks was tendered for the hospitality.

### Winnipeg Medical Society

Reported by R. H. McFarlane

At its recent meeting on the 15th of February, the Society's executive has approved the list of candidates for office as requested by its nominating committee. At the annual meeting this spring the following will be named for consideration: For President, Dr. Hartley Smith; for Vice-President, Doctors Arthur Birt and Earl Stephenson; for Secretary, Doctors Charles Hollenberg and A. W. McCulloch; for Treasurer, Doctors A. T. Gowron and D. L. Kippen and for Trustee, Doctors A. G. Henderson and Dwight Parkinson. Dr. Hartley Smith is currently Vice-President of the Society and it is not now the policy of the nominating committee to attempt to find an opposing candidate for President. However, nominations from the floor at the Annual Meeting for this or any other office are, of course, in order.

The following will be presented for life membership in the Society: Doctors C. M. Strong, E. J. Washington, D. F. McIntyre, N. W. Warner. It always seems to me that the presentation of new life members is one of the more pleasant portions of the program at the Annual Meeting.

The regular meeting of the Society was held at the Medical College on the 17th of February, 1954, and was apparently in competition with at

least one other medical function of some importance. This apparently was the reason for a relatively poor turn out for two interesting and informative papers. The first, entitled "Ionizing Radiation and Cancer," was read by Dr. R. J. Walton, Director of Radiotherapy at the Winnipeg General Hospital. Dr. Walton dealt with a large subject, first, outlining the various types of radiation and their characteristics and uses, and later dealing with the varying means available of applying radiation to various anatomical sites and for varying pathological conditions. I understand this paper will be published in an early number of the Journal.

The second paper, dealing with "Practical Aspects of Anticoagulant Therapy," was presented by Dr. Paul Green. The paper started with a discourse about the properties of the different types of anticoagulants such as Heparin, Dicumarol, Danilone and Tromexan. Their differences in kind and duration of action were discussed as well as their reliability and methods of control. Various indications and contraindications to their use were discussed. A major condition for which anticoagulant therapy is frequently advised, coronary thrombosis, was discussed in some detail and while opinion was not entirely uniform, Dr. Green felt that most authorities found statistical evidence of benefit from this form of treatment. This also co-incided with the opinions of those discussing the paper.



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## Social News

Reported by K. Borthwick-Leslie, M.D.

Hello, and possibly "Goodbye" or should I say "Au Revoir," Today is the day for more X-rays, etc., and maybe poor Gordon won't have to develop more blood pressure waiting for my gossip for another month or so—whose side are you on, Gordon?

\* \* \*

Can't resist commenting on our M.M.S. friends though—Had no idea that my loyal clients were such a threat to the Association, that the very first day I appear back, they announce a probable reduction back to 70%. Very flattering, also very discouraging.

\* \* \*

Can see in the stars that yours truly will be, just one of Pat's "Dollar Hungry" Physicians but not one of the Hungry ones, or has there been too much publicity already?

\* \* \*

Speaking of the M.M.S., congratulations to Dr. McNulty on his well deserved rest from his long term of service so ably conducted, and to Dr. Thorlakson congratulations and sympathy for the headaches he is taking over. Sorry to miss your farewell dinner, Pat, can't take on the social functions in safety yet.

\* \* \*

Congratulations too, to Dr. C. W. Burns on being honored by being elected president of the Surgical Society of Western Canada, and to Dr. James Rennie, hooked for the secretarial duties.

\* \* \*

From here on, apologies are in order, some very old news, but I think still interesting. To those I've missed entirely—Sorry.

\* \* \*

Dr. Robert Macpherson, elected to a Fellowship on the American College of Radiology, an honor noted to members recognized on the basis of outstanding contributions and service in Radiology.

\* \* \*

Dr. John Hildes, the obvious choice for Citizen of the year, in recognition of his almost super-human work during the 1953 polio scourge.

\* \* \*

I was interested in the newspaper picture and report of my old friends Dr. and Mrs. Donald Black of Kelowna, B.C., en route for Toronto where Don is doing post graduate work in Public Health at the University of Toronto.

\* \* \*

Jack Margolis, M.D., has opened his office at 201 Professional Bldg., 407 Graham Ave. Practice limited to Ophthalmology.

Another face from the past—how we fought while in the R.C.A.M.C.—Dr. Cecil G. Sheps, graduate of Manitoba and Yale is now Executive Director of the Beth Israel Hospital in Boston, which I believe serves as a teaching base for Harvard and Tufts College Medical Schools.

\* \* \*

Dr. Harry Medovy has returned from a "tour" in the East. In London, Ont., he attended a meeting of the Paediatric Teachers-Canadian. In Toronto he addressed a staff meeting of the Toronto Sick Children's Hospital. In New York he consulted with the National Foundation re the newest in treatment of Poliomyelitis, the merits of Polio Vaccine, etc. Reports a few enjoyable days of entertainment as well. Sept. 1, 1954, he takes over his new appointment as part time Director of Paediatrics and Professor of Paediatrics, succeeding Dr. Bruce Chown, who is now of retiring age.

\* \* \*

The John and Mary R. Markle Foundation, New York, have announced appointments for 25 Scholars in Medical Science. Congratulations to Reuben Mitchell Cherniak, M.D., M.Sc. U. of (Man.), lecturer in Physiology. Current research fellow department of environmental medicine, Johns Hopkins University. Of special interest Internal Medicine (chest) and Pulmonary Physiology.

\* \* \*

For newcomers, welcome, for change of addresses some are very belated but here they are.

The Manitoba Clinic announces that John Houston McBeath, F.R.C.S. (Edin.), of Glasgow, Scotland, has taken up practice in the Dept. of Urology.

\* \* \*

Dr. S. Margaret Elliott, Queens Graduate, 1947. Post graduate work at State University, Columbus, Ohio, under Dr. Chas. Doan, then in St. Louis and Barnes Hospitals in the Depts. of Medicine and Haematology, associated with Dr. R. E. Beamish, Manitoba Clinic.

\* \* \*

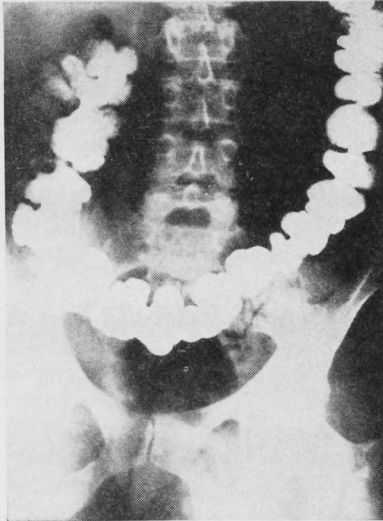
Wallace Arnold McAlpine, F.R.C.S. (Eng.), F.R.C.S. (Edin.), F.C.C.P., formerly instructor of Thoracic Surgery, University of Michigan, is now associated with the Man. Clinic, in his practice of Thoracic and Cardiac Surgery.

\* \* \*

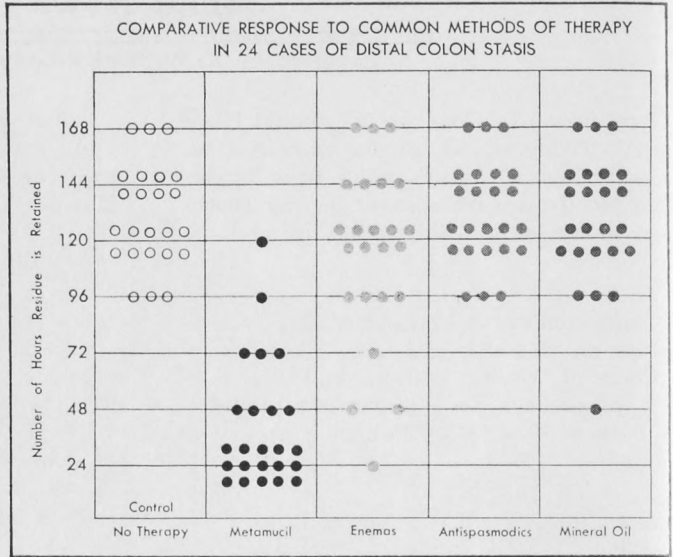
R. T. Ross, M.D., M.R.C.P. (London), has transferred his office from 326 Medical Arts to 611 Medical Arts Bldg., Winnipeg. Practice is confined to Neurology.

(Continued on Page 241)





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It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

\*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. *Rev. Gastroenterol.* 19:154 (Feb.) 1952.

## Social News (continued)

James Lewis Beckstead, M.D., also has moved from 301 Medical Arts to 407 Medical Arts. Practice limited to Internal Medicine.

\* \* \*

Howard Read, M.B., B.S. (Lond.), M.R.C.S. (Eng.), L.R.C.P. (Lond.), M.S. Ophthalmology (Lond.), F.R.C.S. Ophthalmology (Eng.), D.O.M.S. (Eng.), D.O. (Oxon), is associated with the Winnipeg Clinic. Practice is confined to Diagnosis and Treatment of Diseases of the Eye.

\* \* \*

Dr. Lyonel G. Israels announces the opening of his office for the practice of Haematology at 656 Salter St., Winnipeg.

\* \* \*

R. G. d'Agincourt, L.L.B., M.R.C.S. (Eng.), L.R.C.P. (London), F.R.C.S. (Eng.), formerly surgeon, London, Eng., has established his office at 243 Marion St., St. Boniface. General Surgery only.

\* \* \*

Last but not least—Otto Schmidt, M.D., F.R.C.S. (C), M.R.C.O.G., F.A.C.S., has transferred from 523 Medical Arts to 616 Broadway Ave., Winnipeg. Practice limited to Obstetrics and Gynaecology. I miss you and your "Trumpet," Otto, for these hurry up consultations.

\* \* \*

Could be that some of these weddings are far enough in the past that further notices may be expected, but thought the friends, classmates, etc., might be interested.

\* \* \*

July 31, 1953—Laura Rutherford became the bride of Dr. Alexander Arthur Campbell, son of Dr. A. M. Campbell and the late Mrs. Campbell. They reside in Flin Flon, Man.

August 8, 1953—Lois Florence Unsworth and Dr. Ronald D. Ellis, U. of M., 1952, were married. They have taken up residence in Vancouver.

August 9, 1953—Sybil Birstein became the bride of Dr. Samuel Kay, U. of M. Dr. and Mrs. Kay reside in Weyburn, Sask.

September 25, 1953—Audrey Schilling and Dr. Gerald H. Holman exchanged marriage vows. The bride is a graduate of the General Hospital and Dr. Holman a 1953 Man. graduate. I understand Dr. Holman at present is doing post graduate work at the Children's and General Hospital and will continue his studies at Johns' Hopkins.

\* \* \*

January 26, 1954—Reta Taber became the bride of Dr. A. B. Chapman. Dr. and Mrs. Chapman reside in Reston, Man.

January 9, 1954—Janine, daughter of Dr. and Mrs. G. M. LaFleche, became the bride of Hector Moreau. They reside in Winnipeg.

Could be some of our new members are now in kindergarten, but here goes.

August 6, 1953—Dr. and Mrs. W. G. Newman, a son, W. Wm. George.

August 6, 1953—Dr. and Mrs. P. G. Shelton (nee Dr. Elizabeth Malyska), their second son.

August 14, 1953—Dr. and Mrs. G. F. Boulton, a son, Jeffery Hugh.

August 16, 1953—Dr. and Mrs. J. Gerald Fox, a daughter.

May 19, 1953—Dr. and Mrs. J. Oshiro, a daughter, Patricia Lillian.

December 25, 1953—Dr. and Mrs. H. A. Lander, a son, Samuel Mark.

January 5, 1954—Dr. and Mrs. W. A. MacLean, New York City, a daughter, Laurie Ellen.

January 4, 1954—Drs. Gordon and Patricia (nee Knight), a son, Wm. Gordon.

January 26, 1954—Dr. and Mrs. J. S. Holowin, Morris, Man, a daughter.

January 7, 1954—Dr. and Mrs. C. W. Clark, a son. No comment.

Jan. 23, 1954—Dr. and Mrs. D. P. Walmsley, Port Credit, Ont., a daughter.

January 11, 1954—Dr. and Mrs. K. O. Wylie, a daughter, Arleigh Joan.

January 3, 1954—Dr. and Mrs. J. A. Ludwig, a daughter.

January 11, 1954—Dr. and Mrs. John M. Bowman, a daughter, Catherine Jean.

February 18, 1954—Dr. and Mrs. D. E. Lamond, their second son, John Donald.

February 10, 1954—Dr. and Mrs. M. Brook, Beausejour, Man., a daughter.

March 10, 1954—Dr. and Mrs. Bernard Atnikov, a daughter, Janice May.

March 12, 1954—Dr. and Mrs. Gordon Hunter, a daughter, Janice Carol.

Amen.

\* \* \*

To the family, friends and community at large, all of whom will miss her so much, may I present my sympathy for the death of that wonderful lady, Mrs. B. J. Brandon, widow of the late Dr. B. J. Brandon.

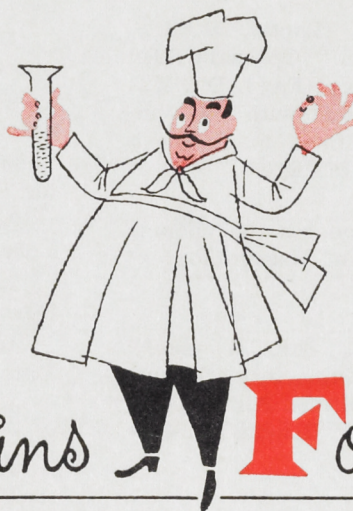
\* \* \*

To my confreres who have so kindly and efficiently cared for my patients during my enforced years absence, my sincere "Thank You."

### Staff Physician Required

Applications will be received for the position of Staff Physician at St. Boniface Sanatorium beginning June 1st, 1954, going salary. Apply to: A. C. Sinclair, M.D., Medical Director, St. Boniface Sanatorium, St. Vital, Manitoba.



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Ferrous Sulphate Exsiccated	125.0 mg.
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Calcium Phosphate Dibasic	250.0 mg.
Magnesium Sulphate	30.0 mg.
Potassium Iodide	0.25 mg.
Cobalt Sulphate	0.25 mg.
Sodium Molybdate	0.25 mg.
Zinc Sulphate	0.5 mg.

*Vitamin**Mineral**Capsule*

**Indications:** As a supplement to the daily diet for the prevention of dietary deficiencies of the above essential substances as may occur in middle and older age groups, pregnancy, lactation, prolonged illness, convalescence, malnutrition, vague conditions and restricted diet due to lack of appetite, or prescribed for reduction in weight, gastro-intestinal conditions and defective absorption.

**Directions:** One capsule or more daily as prescribed by physician.

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ETHICAL PHARMACEUTICALS



## College of Physicians and Surgeons of Manitoba

### Business Arising from Minutes of Executive Committee — September 10, 1953 (Cont.)

#### Re Grant to Medical Library Committee

A communication was read from the Chairman, Medical Library Committee, requesting the usual grant.

**Motion:** "THAT the College of Physicians and Surgeons of Manitoba grant to the Medical Library Committee, the sum of Seven Hundred and Fifty Dollars (\$750.00) for the year 1953-54, to be paid from the Investment Trust Account." Carried.

#### G. Taxing Committee

The Chairman reported no meeting of the Taxing Committee had been held during the year.

#### H. Discipline Committee

The Chairman reported there had been one complaint submitted to the Discipline Committee for investigation. He advised he had forwarded the file to each member of the Committee, and they had met this morning to consider the matter. They agreed to ask the doctor concerned to appear before the members of the Committee.

**Motion:** "THAT the report of the Discipline Committee be adopted." Carried.

#### 5. Reports of Special Committees and Their Consideration

##### A. Representatives to the Manitoba Medical Association Executive

Dr. Ed. Johnson advised he had attended most of the meetings of the Executive of the Manitoba Medical Association, but there was nothing special to report of interest to the College.

**Motion:** "THAT the report of the representatives to the Manitoba Medical Association Executive be adopted." Carried.

##### Request for Grant for Extra Mural Postgraduate Work

A communication was read from the Manitoba Medical Association, requesting the usual grant for extra mural postgraduate work.

**Motion:** "THAT the College of Physicians and Surgeons of Manitoba grant to the Manitoba Medical Association a sum up to Five Hundred Dollars (\$500.00) for the season 1953-54, for extra mural postgraduate work, to be paid from the Investment Trust Account." Carried.

##### Request for Grant for Fee Assessment Committee, Workmen's Compensation Board

A communication was read from the Manitoba Medical Association requesting the usual grant for payment of the Fee Assessment Committee Workmen's Compensation Board.

**Motion:** "THAT the College of Physicians and Surgeons of Manitoba grant to the Manitoba Medical Association, for payment of the Fee Assessment Committee, Workmen's Compensation Board, for the season 1953-54, a sum at the same rate as members of the Council are paid for attending committee meetings." Carried.

##### B. Trustees of the Gordon Bell Memorial Fund

The Registrar reported that the Trustees, Dr. J. S. McInnes, Dr. L. G. Bell and Dr. J. M. Lederman, had sent no communication concerning a candidate to receive this fellowship.

**Motion:** "THAT the report of the Trustees of the Gordon Bell Memorial Fund be adopted." Carried.

##### C. Representatives of the Committee of Fifteen

Dr. W. J. Boyd advised there had been no meetings of the Committee of Fifteen since the May Council meeting.

##### D. Representative to the Committee of Selection in Medicine

The committee met on June 12 in the University Board Room under the chairmanship of the President of the University.

The situation where there were a great excess of applicants to the Course in Medicine has now materially changed, and this year for approximately 70 students there were only 135 applicants, of whom many were below the scholastic standing required, or did not fulfil the necessary required subjects to enter the course. This is a situation which has been gradually developing for a few years, and is to a large extent due to very favorable openings offered to graduates in Engineering and Commerce. This situation, which is dependent upon our prosperous times, may not continue, but for the present, trend is for students to choose courses somewhat easier to take and more remunerative upon graduation.

This has resulted in it being necessary for the committee to accept into the study of Medicine this year students at a lower scholastic level, and whereas in the past we have set to maintain a base line of 65%, this year we accepted as low as 62%, and in fact none of the students who made over 60% in the pre-medical course and fulfilled all subject requirements were excluded. The pre-medical course only supplied less than half of the vacancies, and the others were filled with graduates of our own and neighboring Universities who had fulfilled requirements for entrance.

The personal qualifications of the applicants were reviewed in so far as they were available to us and taken into consideration in addition to the scholastic attainments as listed, and in some cases

personal interviews to supplement available information were arranged.

Yours truly,

T. H. Williams, M.D., C.M.,  
Representative on Committee of  
Student Selection for Medicine.

**Motion:** "THAT the report of the Representative to the Committee of Selection in Medicine be adopted." Carried.

#### **E. Representative to the Medical Council of Canada**

1. Doctors C. E. Corrigan and C. H. A. Walton are your Representatives in the Medical Council of Canada: The latter is making this report because Doctor Corrigan, your Senior Representative, is also President of the College and cannot report effectively from the chair.

2. Many matters were considered at the Annual Meeting of Council: A request that the subject of paediatrics be included in the Medical Council of Canada examinations was considered and was referred to the Committee on Education for study.

3. Whenever a name is struck from a Provincial Medical Register, the Medical Council of Canada is notified and erasure from its Register is carried out. The College of Physicians and Surgeons of Ontario reported that it had erased the name of one of its members on a charge of unprofessional conduct and had, in due course, notified the Registrar of the Medical Council of Canada. In Ontario the law permits a doctor so erased to appeal the decision of the College to the Supreme Court of Ontario within six months; in the case under review, the doctor had engaged the services of counsel and had notified the Ontario College that he would enter an appeal. Some five and a half months had elapsed and the question before the Medical Council of Canada was—"should this doctor's name be erased from its Register, pending decision of the Appeal Court." This matter is reported at some length for the information of Council.

4. A few changes were made in the Main Board of Examiners and among the Oral and Clinical Examiners but none in Manitoba.

5. The Rules and Regulations of the Medical Council amended at the Meeting of the Council in September, 1952, have been approved by the Governor General in Council and are now published as a fourth edition dated May, 1953. The most important changes are first, the removal of the word "permanent" from the Enabling Certificate and the requirement, under paragraph Forty-three of the Rules and Regulations which says: "Any person who graduates in Medicine on, or after, the first of January, 1954, can become registered under the Canada Medical Act only, (a) by passing the Examinations of the Medical Council of Canada, and (b) upon submitting evidence that he has completed one year of satisfactory interne-

ship in a hospital or hospitals approved for internship by the licensing body in which the candidate is seeking licensure." The amended regulation requiring internship is in line with requirements in this Province and in many other Provinces. The College of Physicians and Surgeons of Ontario continue to object to the requirement and reopened debate on the new regulation. However, the regulation still stands and it is hoped that it will be tested in the courts.

6. A matter of great importance to this College was that relating to the cancellation of the Enabling Certificate issued by this College. The problem relating to this applicant was dealt with in the report of the Registration Committee. The Medical Council of Canada concurred in the action of this College and withdrew the privilege of the examination from Mr. \_\_\_\_\_.

7. It has been the practice of our Registrar to endorse many of the Enabling Certificates granted to foreign applicants with the words, "it is agreed that the examinations will be written in Winnipeg." The Registrar of the Medical Council of Canada had taken objection to this endorsement and had sought advice from a solicitor: The Medical Council of Canada ruled that it was within the right of the Provincial Licensing Body to endorse an Enabling Certificate as we have been doing and to require examination be taken in a particular centre.

8. Doctor Emmet McCusker of Regina was elected President of the Medical Council of Canada. The Registrar, Doctor J. Fenton Argue, announced his intention of retiring in September, 1954. The Executive of Council will concern itself in the next twelve months with the appointing of a successor for Doctor Argue.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

16 October, 1953.

**Motion:** "That the report of the Representative to the Medical Council of Canada be adopted." Carried.

#### **F. Representative to the University Senate**

1. I have attended all the meetings of the Senate of the University and no problems of special interest to this College were considered by the Senate other than those relating to the Bachelor of Science Act.

2. Following the meeting of Council in May the Senate was requested to make available facilities for the evaluation of the credentials submitted by applicants to the College for registration on Enabling Certificates. The Senate was sympathetic to our request and acting under the authority of the University Act and of Section Seventy-five of the Medical Act, appointed a Committee of Credentials from the Faculty of Medicine. This Committee receives all documents referred to it by your Registration Committee and decides whether

or not the particular candidate is qualified in the basic sciences and if not, arranges for suitable examinations. A number of these examinations were held in September and the University and its Committee and Examiners have been most co-operative in assisting the College in the evaluation of Medical Applicants. In my judgment, the new method described above, replaces all the essentials of the Basic Science Act and indeed is preferable because it is more flexible.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

16 October, 1953.

**Motion:** "THAT the report of the Representative to the University Senate be adopted." Carried

Dr. Walton stated he wished to elaborate on the new regulations set up by the University of Manitoba to assess qualifications of foreign physicians referred by the College, and presented the following outline:

**Recommended plan for implementation of request of the College of Physicians and Surgeons of Manitoba that the Senate of the University set up machinery for assessment of credentials of certain candidates for Enabling Certificates and Licensure.**

The Medical Faculty Council Executive recommends that a Credentials Committee be established for the purpose of assessing credentials of such applicants for enabling certificates and licensure as might be referred to it by the College of Physicians and Surgeons of Manitoba. Subjects to be considered are Anatomy, Biochemistry, Physiology and Pathology and Bacteriology combined.

The Committee recommends that:

(1) Applications should be received only through the C.P. & S. of Manitoba.

(2) These will be referred to the Committee on Credentials.

(3) Personnel of the Committee on Credentials: A Chairman and Secretary to be named by the Dean. Representatives of the Departments teaching the Basic Sciences. The Chairman of the Registration Committee of the C.P. & S. (perhaps in an advisory capacity and for liaison). (Where there is a question of advanced standing involving clinical subjects, the Committee may have power to add).

(4) The standard of adequacy in the Basic Sciences shall be the prevailing standards of the University of Manitoba.

(5) If, in the judgment of the Committee, the applicant's standing in the Basic Sciences is adequate, the C.P. & S. will be so informed with notification to the Registrar of the University.

(6) If the applicant is judged inadequately qualified in a subject or subjects, the C.P. & S. and the Registrar will be so informed. The C.P. & S. will then instruct the applicant to apply to the Registrar for permission to write the required

examinations, the results of which will be reported to the Committee and the C.P. & S.

(7) The onus of supplying adequate information upon which to base a decision in this matter rests upon the applicant. If the information is inadequate in this respect, the applicant will be required to write examinations in the subjects concerned.

(8) The Committee will be prepared to recommend a roster of examiners on request of the Registrar.

(9) Examinations will be set upon the basis of a reasonable knowledge of the subject concerned, as set forth in the following textbooks: Anatomy—Gray; Anatomy. Biochemistry—Thorpe: Biochemistry for Medical Students. Kleiner: Human Biochemistry. Bodansky and Bodansky: Biochemistry of Disease. Physiology—Samson Wright: Applied Physiology. Bacteriology—Mackie and McCartney: Handbook of Practical Bacteriology. Pathology—Boyd: Textbook of Pathology.

(10) It is recommended that the University conduct not more than two examination series annually for candidates referred for examination to the University by the C.P. & S. The examinations should be held well in advance of the Dominion Council examinations in May and October.

(11) That there be a documentation fee of \$5.00 to be collected by the C.P. & S. It is suggested that the Registrar bill the C.P. & S. for the total number of applicants examined by the Committee, at the end of each month.

(12) It is recommended that the present schedule of fees for examinations and remuneration to examiners be the same as obtained under the Basic Sciences Act.

#### **Regulations Pertaining to the Writing of Basic Sciences Examinations**

1. Examinations in the Basic Sciences will be conducted commencing the first week in April and the first week in September.

2. Candidates are obliged to file application for the examinations at least thirty days in advance of the date of examinations.

3. The fee for each examination is Twenty Dollars (\$20.00).

4. Three hours will be allotted to each written examination.

5. Candidates are required to pass in each examination.

6. The passing grade in all examinations of the Basic Sciences is 50%, the maximum mark in each paper being 100%.

7. Examinations may be either written and/or practical or oral—final form to be left to the discretion of examiners.

8. A candidate who fails one or more papers may sit supplemental examinations at the succeeding examination series.

The Registrar said the recommendations had



been accepted, and that 19 applications had already been considered, and the College had paid the University \$5.00 for each applicant out of the Documentation Fee.

**Motion:** "THAT the College of Physicians and Surgeons collect an additional fee of Five Dollars (\$5.00) from applicants whose documents are referred to the Credentials Committee of the University of Manitoba, which will be transferred to the University by the College." Carried.

#### G. Representatives to the Cancer Institute

The Registrar stated that he and the President of the College, together with the Minister of Health were ex-officio members of the Institute, and that another member of Council, Dr. C. H. A. Walton was a representative of the Manitoba Medical Association. He attended all meetings including the Annual Meeting. The new organization was outlined in May, and the reorganization is proceeding with Dr. R. J. Walton, a qualified radiotherapist who arrived this month.

**Motion:** "THAT the report of the Representatives to the Cancer Institute be adopted." Carried.

#### H. Representatives to the Liaison Committee,

##### M.M.A. & C.P. & S.

Dr. C. B. Stewart reported there had been one meeting of the Liaison Committee held since the May meeting, to consider the purchase of a new addressing system for the combined office. The Executives of both bodies had recommended the purchase of an addressograph machine, which would curtail the work a great deal since the one in use at the present time is antiquated.

The Liaison Committee recommended that an addressing system be purchased; that the Executive Secretary be empowered to investigate types available, and purchase most suitable after consultation with Drs. C. B. Stewart, and C. W. Wiebe; and that the present 40% C.P. & S., 60% M.M.A. ratio be maintained for initial \$300.00 outlay—proportionately less if decision to purchase power operated machine costing approximately \$600.00.

**Motion:** "THAT the report and recommendation of the Liaison Committee—M.M.A. & C.P. & S. be adopted." Carried.

#### I. Representative to the Canadian Arthritis and Rheumatism Society (Manitoba Division)

The Registrar reported he had been named to the Medical Advisory Committee of the C.A.R.S., but had been unable to attend the Annual Meeting. The Provincial Division will be host to the Canadian Society later this month.

**Motion:** "THAT the report of the Representative to the Canadian Arthritis and Rheumatism Society (Manitoba Division) be adopted." Carried.

#### J. Representatives to the Specialist Committee

1. Your Committee has met twice in the past year. Sixty-three applicants have been registered on the basis of Royal College of Canada standing: Twenty-four other applicants without Royal

College standing were considered and ordered to be registered. The Specialist Register now contains eighty-seven names.

2. Seven applicants are still outstanding. Those of Doctors \_\_\_\_\_ were deferred pending the results of current Royal College Examinations. Three applicants gave your Committee considerable difficulty: These applicants are, Doctor \_\_\_\_\_, desiring registration as a specialist in Industrial Medicine; Doctor \_\_\_\_\_, Aviation Medicine, and Doctor \_\_\_\_\_, in Compensation Medicine. It was the opinion of the Committee that these specialists could not at present be registered; the Canadian Royal College does not certify in any of these specialties nor does it contemplate doing so. It is difficult to develop suitable criteria which would be comparable to the other specialties. These three applications are drawn to the attention of Council for its consideration.

3. Under the By-law setting up the Specialist Register, all applicants after the 31st of December 1953, who desire specialist registration are required to have Certification or Fellowship in the Royal Colleges of Canada. Applicants, other than those with Royal College standing, after that date could only be considered by Council. It is the intention of the Specialist Committee to meet again early in January, 1954, for the purpose of considering applications received prior to December 31st, 1953. The Committee will then dissolve.

All of which is respectfully submitted.

C. H. A. Walton, M.D.

16 October, 1953.

**Motion:** "THAT the report of the Representatives to the Specialist Committee be adopted." Carried.

Dr. Ed. Johnson remarked on the low number of specialists applying for specialist registration and it was agreed to publish additional notices in the Manitoba Medical Review drawing attention to the cut off date of December 31, 1953, as it was those without Royal College standing who would have to be considered by Council after that date.

Dr. Walton mentioned the three physicians who wished recognition in their specialty, but there was no way of evaluating their qualifications since the Royal College does not certify any of the specialties. It was agreed to defer the applications of Doctors \_\_\_\_\_, pending establishment of credit in their specialties in the future, at which time their applications could be reconsidered by the Council.

#### 6. Election of Officers and Standing Committees

##### Officers

##### A. President

**Motion:** "THAT Dr. T. W. Shaw be appointed President." Carried.

##### B. Vice-President

**Motion:** "THAT Dr. C. H. A. Walton be appointed Vice-President." Carried.

**C. Registrar**

**Motion:** "THAT Dr. M. T. Macfarland be appointed Registrar." Carried.

**D. Treasurer**

**Motion:** "THAT Dr. T. H. Williams be appointed Treasurer." Carried.

### **Nomination Committee to Strike Standing Committees**

The President appointed Doctors Ed. Johnson, S. S. Toni and W. J. Boyd, as a Committee to Strike Standing Committees.

Dr. C. E. Corrigan vacated the Chair, in favour of the newly elected President, Dr. T. W. Shaw.

### **Standing Committees**

**A. Registration Committee:**

Dr. C. H. A. Walton, Chairman  
Dr. F. H. Smith  
Dr. C. E. Corrigan

**B. Education Committee:**

Dr. A. R. Birt, Chairman  
Dr. A. L. Paine  
Dr. W. J. Boyd

**C. Finance Committee:**

Dr. T. H. Williams, Chairman  
Dr. F. K. Purdie  
Dr. B. Dyma

**D. Legislative Committee:**

Dr. W. J. Boyd, Chairman  
Dr. A. L. Paine  
Dr. S. S. Toni  
Dr. C. E. Corrigan  
Dr. A. R. Birt

**E. Discipline Committee:**

Dr. Ed. Johnson, Chairman  
Dr. Wm. Watt  
Dr. W. J. Boyd  
Dr. Wm. Malyska  
Dr. A. P. Guttman

**F. Executive Committee:**

Dr. C. B. Stewart, Chairman  
Dr. G. H. Hamlin  
Dr. Ed. Johnson  
Dr. C. H. A. Walton  
Dr. A. R. Birt

**G. Library Committee:**

Dr. T. H. Williams

**H. Taxing Committee:**

Dr. C. B. Stewart, Chairman  
Dr. B. Dyma  
Dr. P. Johnson

**Motion:** "THAT the appointment of Standing Committees be accepted." Carried.

### **Election of Special Committees**

#### **A. Representatives to the Manitoba Medical Association Executive**

**Motion:** "THAT our representatives to the Manitoba Medical Association Executive be Dr. Ed. Johnson and Dr. C. B. Stewart." Carried.

#### **B. Representatives to the Committee of Fifteen**

**Motion:** "THAT our representatives to the Com-

mittee of Fifteen be Dr. W. J. Boyd, Dr. F. K. Purdie and Dr. Ed. Johnson." Carried.

#### **C. Representative to the Committee of Selection in Medicine**

**Motion:** "THAT our representative to the Committee of Selection in Medicine be Dr. T. H. Williams." Carried.

#### **D. Representatives to the Medical Council of Canada**

The Registrar pointed out that Dr. C. E. Corrigan and Dr. C. H. A. Walton were appointed our representatives to the Medical Council of Canada for a period of four years, on October 11th, 1952; and it was agreed that no change be made.

#### **E. Representative to the University Senate**

**Motion:** "THAT our representative to the University Senate be Dr. C. H. A. Walton as agreed at the May Council Meeting." Carried.

Dr. Walton suggested that the College representatives to the Medical Council of Canada and the University Senate are not strictly special committees but are statutory appointments laid down in the Canada Medical Act and the University of Manitoba Act. This matter was referred to the Legislative Committee for consideration.

#### **F. Representatives to the Liaison Committee—M.M.A. & C.P. & S.**

**Motion:** "THAT our representatives to the Liaison Committee—M.M.A. & C.P. & S. be Dr. C. B. Stewart, Dr. F. K. Purdie and Dr. Ed. Johnson." Carried.

#### **G. Representative to the Canadian Arthritis and Rheumatism Society (Manitoba Division)**

**Motion:** "THAT our representative to the Medical Advisory Committee, Canadian Arthritis and Rheumatism Society (Manitoba Division), be Dr. A. P. Guttman." Carried.

### **Appointment of Auditors**

**Motion:** "THAT the appointment of Auditors be deferred to the May Meeting of Council." Carried.

### **7. Reading of Communications, Petitions, etc., to Council**

#### **A. Communication From United Kingdom Trade Commissioner**

The Registrar read a letter dated September 21st, 1953, from the United Kingdom Trade Commissioner, Winnipeg, addressed to the Manitoba Medical Association and referred to the College, advising that a British firm wished to export to Canada a device called the Simplicity Ear Piercer, and inquiring whether the responsible professional body had any power to govern the use of the instrument and whether it could be properly employed by an ordinary jeweller. The letter outlined the method of using the ear piercer, and stated that the kit for performing the operation had been inspected by the Federal Department of National Health and Welfare who advised that the device itself was not subject to Federal Legis-



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lation although the local anaesthetic supplied with it must be labelled in accordance with the Food and Drug Act.

It was agreed that the College had no jurisdiction in this matter, since it is a device used by persons not members of the College of Physicians and Surgeons of Manitoba.

### B. Communication From the Newfoundland Medical Board

The Registrar read a letter dated October 8th from the Registrar of the Newfoundland Medical Board, advising that their President, Dr. Nutting Stuart Fraser, O.B.E., had passed away on October 6th in his 90th year. He reported that a letter expressing the sympathy of the President and members of the Council of this College, had been forwarded.

### C. Change of Name of Solicitor's Firm

The Registrar presented an announcement card that D. A. Thompson, Q.C., and Dilts, Laidlaw, Shepard, Dilts & Jones had formed a new partnership to carry on the general practice of law from November 16th, 1953, under the name of Thompson, Shepard, Dilts & Jones.

**Motion:** "THAT the firm of Thompson, Shepard, Dilts & Jones be appointed solicitor for the College with the request that Mr. T. W. Laidlaw, with the assistance of Mr. David H. Jones, be made available to the College when required." Carried.

### 8. Inquiries

The Registrar advised there was still a large number of inquiries being received from European Doctors. These have been answered without being brought before Council or Registration Committee.

### 9. Notices of Motion

**Notice of Motion by Dr. W. J. Boyd:** "THAT the By-laws, Rules and Regulations of the College of Physicians and Surgeons of Manitoba be consolidated in conformity with the 1953 amendments to the Medical Act, and changes recommended to-date by Council." Carried.

### 10. Motions of Which Notice Has Been Given at Previous Meetings

None.

### 11. Unfinished Business

None.

### 12. Miscellaneous and New Business

#### A. Payment of Janitor and Luncheon

**Motion:** "THAT the sum of Five Dollars (\$5.00) be paid to the janitor for his services, and that the sum of Thirty Dollars (\$30.00) be paid for the luncheon." Carried.

#### B. Amount to be Paid to Council Members for This Meeting

**Motion:** "THAT the amounts paid to members of Council for attendance at this meeting be at the usual rate." Carried.

#### C. Salaries and Amount to be Paid to the M.M.A. Each Month

**Motion:** "THAT the following salaries be paid



Registrar, Three Hundred Dollars (\$300.00) per month; Treasurer, Six Hundred Dollars (\$600.00) per annum; Assistant to the Registrar, Two Hundred and Twenty-five Dollars (\$225.00) per month; and Stenographer, One Hundred and Sixty-five Dollars (\$165.00) per month." Carried.

**Motion:** "THAT the amount of Eighty Dollars (\$80.00) be paid to the Manitoba Medical Association each month for services, as arranged by the Liaison Committee." Carried.

#### D. Adjournment

**Motion:** "THAT the meeting be adjourned." Carried.

### 1954 Schering Award Subjects Announced

To encourage scientific reporting and to stimulate medical students' interest in the ever expanding fields of therapy, the Schering Award Committee has announced the beginning of the ninth consecutive competition in 1954.

Titles of three subjects on which students in the United States and Canada are being invited to submit papers have been made known by George Babcock, Jr., M.D., chairman of the committee. They are:

(1) The Use of Androgen Therapy in the

Female.

(2) The Prophylactic and Therapeutic Uses of Parenteral Antihistamines.

(3) Modern Treatment of Infections and Allergic Disorders of the Eye.

For the best paper on each of these subjects, the committee will present one \$500 first prize and a \$250 second prize. Special citations and professionally useful gifts will also be awarded to all students who submit papers of merit. Outstanding medical authorities in each field will judge the papers.

Deadline for entry forms specifying the student's chosen title is July 1. All manuscripts must be mailed not later than October 1. Students may compete individually or co-operatively in research teams.

The purpose of the Schering Award is to encourage original reporting in the hope that students will later contribute to the essential communications of knowledge throughout the medical profession.

The Schering Award Committee will bring outstanding papers to the attention of editors of appropriate professional journals. Information and instructions for the competition are available from Schering Corporation, 2 Broad Street, Bloomfield, N.J.

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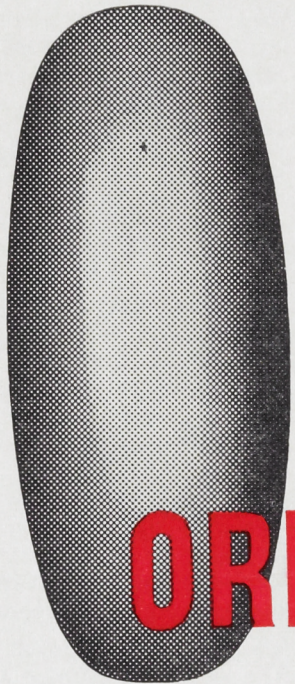
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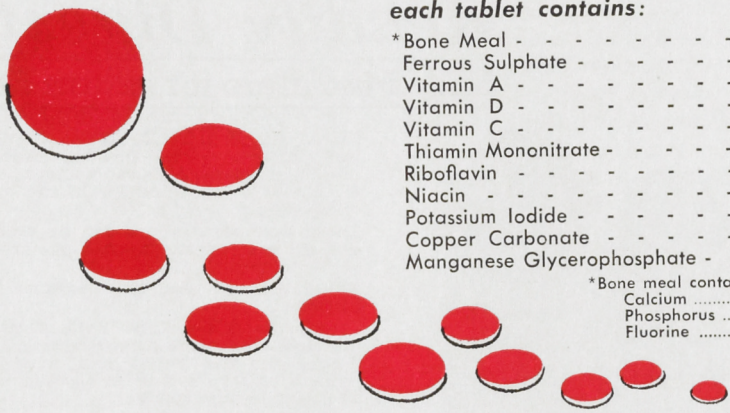
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**Department of Health and Public Welfare**  
**Comparisons Communicable Diseases — Manitoba (Whites and Indians)**

DISEASES	1954		1953		Total	
	Jan. 24 to Feb. 20, '54	Jan. 1 to Jan. 23, '54	Jan. 25 to Feb. 21, '53	Jan. 1 to Jan. 24, '53	Jan. 1 to Feb. 20, '54	Jan. 1 to Feb. 21, '53
Anterior Poliomyelitis	3	6	6	6	14	12
Chickenpox	187	192	148	176	379	324
Diphtheria	0	0	0	3	0	3
Diarrhoea and Enteritis, under 1 yr.	14	8	11	1	22	12
Diphtheria Carriers	0	0	0	0	0	0
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	3	0	2	0	3	2
Erysipelas	3	1	5	0	4	5
Encephalitis	0	0	0	0	0	0
Influenza	7	4	12	1	11	13
Measles	81	57	699	539	138	1238
Measles—German	5	0	7	5	5	12
Meningococcal Meningitis	2	0	1	4	2	5
Mumps	150	62	188	127	212	315
Ophthalmia Neonatorum	0	0	0	0	0	0
Parotid Fever	0	0	0	0	0	0
Scarlet Fever	70	61	66	40	131	106
Septic Sore Throat	3	5	2	0	8	2
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	0	0
Trachoma	0	0	0	0	0	0
Tuberculosis	31	7	58	12	38	70
Typhoid Fever	2	0	0	0	2	0
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	0	0	0	0	0	0
Undulant Fever	0	0	0	0	0	0
Whooping Cough	5	4	16	8	9	24
Gonorrhoea	95	101	84	110	196	194
Syphilis	8	3	2	7	11	9
Infectious Jaundice	33	14	22	12	47	34

Four-week Period January 24th to February 20th, 1954

**\*DEATHS FROM REPORTABLE DISEASES**

For the Month of February, 1954

DISEASES	*809,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	2,952,000 Minnesota
(White Cases Only)				
Approximate population.				
Anterior Poliomyelitis	8	6	2	13
Chickenpox	187	328	2001	---
Diarrhoea and Enteritis, under 1 yr.	14	12	---	---
Diphtheria	---	1	---	---
Diphtheria Carriers	---	---	---	---
Dysentery—Amoebic	---	1	---	3
Dysentery—Bacillary	3	---	44	15
Encephalitis Epidemica	---	---	---	---
Erysipelas	3	---	4	---
Influenza	7	---	25	6
Infectious Jaundice	33	116	173	243
Measles	81	91	1339	56
German Measles	5	45	152	---
Meningitis Meningococcus	2	4	8	7
Mumps	150	477	1250	---
Ophthal. Neonat.	---	---	---	---
Parotid Fever	---	---	---	---
Scarlet Fever	70	42	582	272
Septic Sore Throat	3	14	6	29
Smallpox	---	---	---	---
Tetanus	---	---	---	---
Trachoma	---	---	---	---
Tuberculosis	31	37	120	87
Tularemia	---	---	---	---
Typhoid Fever	2	1	---	---
Typh. Para-Typhoid	---	---	2	---
Typhoid Carriers	---	---	---	---
Undulant Fever	---	---	1	13
Whooping Cough	5	6	207	42
Gonorrhoea	95	---	217	---
Syphilis	8	---	83	---

**Urban**—Cancer, 43; Pneumonia Lobar, 4; Pneumonia (other forms), 6; Tuberculosis, 1. Other diseases attributable to viruses, 1; Diarrhoea and enteritis, 2. Other deaths under 1 year, 27. Other deaths over 1 year, 173. Stillbirths, 13. Total, 213.

**Rural**—Cancer, 33; Pneumonia, Lobar, 2; (other forms), 11; Pneumonia of Newborn, 3; Tuberculosis, 4; Diarrhoea and Enteritis, 4. Other deaths under 1 year, 13. Other deaths over 1 year, 146. Stillbirths, 11. Total, 170.

**Indians**—Pneumonia (other forms), 2. Other deaths under 1 year, 3. Other deaths over 1 year, 5. Stillbirths, 1. Total, 9.

A few sporadic cases of **Poliomyelitis** are being reported.

**Diarrhoea and Enteritis** under the age of one year is, as always, a problem.

**Infectious Jaundice** (hepatitis) is fairly common and almost epidemic in some areas.

**Scarlet Fever** is mildly epidemic in some areas.

**Rabies in Animals**—A fox and a coyote from the Petersfield-Clandeboyne district were both found to be suffering from this infection. A coyote from near Libau was a possible case and a red fox from Aubigny in Rural Morris was a proven case. It is probable that the infection is fairly widespread in wild animals in eastern Manitoba and we should be watching our dog population for any peculiar symptoms. These sick dogs should **not be killed** but be safely confined until they die or a diagnosis can be made.



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